



THERAPY AND ASSESSMENT CLINIC

CHILD & ADOLESCENT THERAPY CLINIC

COMMUNITY COUNSELING CLINIC

2109 S. NORTON AVENUE, SIOUX FALLS, SD 57105 | P: 605.334.2696 F: 605.339.9944 W: offermehope.com

Consent to Release or Obtain Information

This is consent for release of information about: _____
(Client Name)

Social Security Number: _____ - _____ - _____ Birth Date: _____

I authorize Sioux Falls Psychological Services (SFPS) and _____
(Therapist)

to release/exchange to: _____
(Name of persons or organizations)

Address: _____

Fax: _____ Phone: _____

For the purpose of: _____

- I understand that I am authorizing SFPS and those identified below to release and exchange information. The information I authorize a person or entity to receive may not be re-disclosed and no longer protected by federal privacy regulations.
- I understand that unless noted this release shall be reciprocal, allowing both SFPS and the source noted below to receive and exchange information.
- I understand that my written notice to SFPS will revoke this consent at anytime.
- I understand that I will be informed of requests for information.
- I understand that I may review any information being disclosed or copy the information used.
- I understand that information regarding my care may be shared internally to assure effective services.
- I understand that unless noticed this release can be transmitted by facsimile.

THE INFORMATION WILL BE USED/DISCLOSED FOR THE FOLLOWING PURPOSES:

- | | |
|--|---|
| <input type="checkbox"/> Acknowledgement of Referral | <input type="checkbox"/> Social/Historical Past/Current |
| <input type="checkbox"/> Past/Current Assessment | <input type="checkbox"/> Recommendations/Plans |
| <input type="checkbox"/> Diagnostic Information | <input type="checkbox"/> Medical/Medication |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Community Support |
| <input type="checkbox"/> Legal Orders/Filings | <input type="checkbox"/> Discharge Summaries |
| <input type="checkbox"/> Progress | |
- Other (specify): _____

This authorization expires on: _____

Client/Guardian Name (please print): _____

Relationship to Client: _____

Client/Guardian Signature: _____ Date: _____