SIOUX FALLS PSYCHOLOGICAL SERVICES | STRONGHOLD COUNSELING SERVICES, INC. "A House on the Rock" | river COUNSELING SERVICES

Central Mailing Address: 2109 S. NORTON AVENUE, SIOUX FALLS, SD 57105
Phone: 605.334.2696 / 605.334.7713 Fax: 605.339.9944 / 605.334.5348

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, Stronghold Counseling Services, or River Counseling Services (SFPS, Stronghold, or River) and _____
(Provider)

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

Address: _____

Fax: _____ Phone: _____

For the purpose of: _____

- I understand that I am authorizing SFPS/SCS/River those identified above 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/SCS/River and the source noted below to receive and exchange information.
- I understand that my written notice to SFPS/SCS/River will revoke this consent at any time, except to the extent that action has been taken in reliance on it, by sending written notification to the Clinical Director at the above address.
- I understand that SFPS/SCS/River will not condition the provision of treatment or payment on the provision of this authorization.
- 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:

_____ Acknowledgement of Referral
_____ Past/Current Assessment
_____ Diagnostic Information
_____ Case Management
_____ Legal Orders/Filings
_____ Progress
_____ Social/Historical Past/Current
_____ Recommendations/Plans
_____ Medical/Medication
_____ Community Support
_____ Discharge Summaries
_____ Request of client or authorized representative

Other (specify): _____

This authorization expires on: _____

Client/Guardian Name (please print): _____

Relationship to Client: _____

Client/Guardian Signature: _____ Date: _____