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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:

_____ 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

Other (specify): ____

This authorization expires on: ____

Client/Guardian Name (please print): ____

Relationship to Client: ____

Client/Guardian Signature: ____ Date: ____________