Black Hills Counseling Services

1238 Main Street, Surgis, SD 57785
(605) 720-8090

AUTHORIZATION FOR
RELEASE OF INFORMATION

I, ____, hereby authorize Black Hills Counseling and the facility, agency, or person named below to mutually exchange specified information concerning me and/or my child/ward's care. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ______________ If not otherwise specified, this authorization will automatically expire in 180 days.

Name and address of facility or person to which exchange is to be made:

____

____

This data shall include: (check appropriate box) ❑ Verbal Information Only – no records will be sent.

❑ Psychosocial Evaluation ❑ Progress Notes ❑ Discharge Summary ❑ Psychiatric Eval. ❑ CD Evaluation
❑ Patient status and progress toward Discharge. ❑ Other____

____

The purpose of releasing this data shall be: ❑ Continuity of Care ❑ Discharge Planning
Other:____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the facility listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to receive treatment, payment or other benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

FOR THE RECIPIENT OF THE INFORMATION:
The information disclosed includes psychiatric care, and may include the following:
❑ AIDS/HIV treatment; ❑ sickle cell anemia ❑ drug and alcohol treatment/evaluation.
If the information released contains drug and alcohol diagnosis or treatment information, the following applies:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I have read this authorization and request, and it is fully understood and made voluntarily on my part.

Executed this _______________ date of ____, 20________

____
Signature of Patient

____
Signature of Witness

____
Signature of: (Check one)
Parent ❑ Guardian ❑ Other ____________________
(When Required)