SIOUXLAND CHILD & ADOLESCENT
THERAPY SERVICES, LLC

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AUTHORIZATION TO RELEASE INFORMATION

As a recipient of Title XIX or Title XX benefits, I understand that my file may be reviewed by the Utilization Review Committee and appropriate state or federal officials. The Utilization Review Committee is made up of mental health professionals from mental health centers in South Dakota. I understand that the purpose of this review is to assure that Title XIX and Title XX recipients are receiving services for which Title XIX and Title XX are being billed.

It is my understanding that my file will be treated with the strictest degree of confidentiality by the members of this committee and state and federal officials, and that a written copy of my file will be maintained only at Siouxland Child & Adolescent Therapy Services, LLC. My signature authorizes the release of information from my file to the Utilization Review Committee and state and federal officials for the purpose stated above. I understand that I may withdraw this consent by written notice at any time. I understand that if I withdraw my consent, Title XIX and Title XX benefits will cease.

____________________________ ____________________________
(Date) (Signature)

____________________________ ____________________________
(Witness) (Parent/Guardian or Legal Custodian)