SIOUXLAND CHILD & ADOLESCENT THERAPY SERVICES, LLC

3700 S. Kiwanis Ave. Suite 4
Sioux Falls, SD 57105
(605) 271-7117
Email: info@siouxlandtherapy.com
Website: siouxlandtherapy.com

AUTHORIZATION

For the use and/or disclosure of health information

Client / Patient Identification	Name:______________________ Date of Birth:__________ Address:______________________ Phone:__________ City/State/Zip:______________________ Maiden/Previous Names:______________________
Provider Information	Provider:______________________ Siouxland Child & Adolescent Therapy Services, LLC 3700 S Kiwanis Ave, Suite 4 Sioux Falls, SD 57105
Information Use: ❒Disclose to and/or ❒Receive From	Name/Facility:______________________ Address:______________________ City/State/Zip:______________________ Phone:______________________ Fax:__________
Information to be Disclosed and/or Received	❒Evaluation ❒Treatment Summary ❒Psychological Testing ❒Court / Legal ❒Other:______________________
Purpose	❒Continuing Care ❒Other:______________________ ❒Court / Legal ______________________ ❒Personal ______________________
Expiration Date	This authorization will expire one year from the date of signature, or on:__________.
Revocation	I understand that I may revoke this authorization at any time by sending a written notice to the provider or facility noted above. However, the revocation is not valid if (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; when the law allows my insurance company to contest a claim under my policy.
Authorization	I hereby authorize the above facility/provider to use or disclose medical information regarding the above named client to the party identified. I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once this information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that Siouxland Child & Adolescent Therapy Services, LLC is not responsible for interpretation and/or dissemination of report to others. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment or eligible benefits. ______________________ ______________________ Signature of client or legal representative Date of Signature ______________________ ______________________ Relationship to client Witness Signature (optional)
	The following applies to Substance Abuse Records Only: This information has been disclosed to you from the records protected by Federal confidentially 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.