Human Service Agency

Authorization To Disclose Health Information

CID#:

Name:

DOB:

I authorize the Human Service Agency,123 19th Street N.E., PO Box 1030, Watertown, South Dakota 57201 Fax #605-886-5447 to **both disclose and request** the above named individual's health information as described below.

- ☒ **Social History/Needs Assessment**
- ☒ **Diagnosis**
- ☒ **Treatment Plans**
- ☒ **Attendance/Participation**
- ☒ **Case Management**
- ☒ **Alcohol/Drug/Gambling Information**
- ☒ **Psychiatric/Psychological Evaluation**
- ☒ **Copy of Consults**
- ☒ **Recommendations**
- ☒ **Financial Information**
- ☒ **TB Results**
- ☒ **Discharge Summary**

☐ **Progress Notes**

Other:

The information identified above may be **both disclosed to and/or requested from** the following individuals or Organization(s):

☒ **I AGREE** THE RECORDS RECEIVED FROM A REFERRAL AGENCY MAY BE RE-DISCLOSED TO A SECONDARY TREATMENT FACILITY

Name of Facility:

Address:

Fax Number:

The information for which I'm authorizing disclosure will be used for:

For non-state funded clients, information released to the SD Department of Social Services, Division of Community Behavioral Health will be for statistical purposes only and will not include personally identifiable information.

I understand that I have the 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 Human Service Agency. 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.

This authorization will expire (date or event) 60 DAYS AFTER CESSATION OF SERVICES

- I have had an opportunity to ask questions about the use or disclosure of my health information.
- If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.
- I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.
- I understand services for alcohol and drug purposes are protected under CFR 42 Part 2 and the Health Insurance Portability and Accountability Act of 1996 ('HIPAA'), 45 C. F. R. Pts. 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

- The client information may be shared between Behavioral Health Clinicians to provide effective/comprehensive treatment.

Signature of Patient or Legal Representative If signed by legal representative, relationship to patient:	Date

Witnessed By	Date

********CONFIDENTIAL**********

This information has been disclosed to you from records protected by Federal confidentiality rules (CFR 42 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 CFR 42 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 this information to criminally investigate or prosecute any alcohol or drug abuse patient.