BROOKINGS
behavioral health & wellness

Authorization to Exchange Information

211 4th Street Brookings, South Dakota 57006 Phone: 605.697.2850 Fax: 605.697.2874

Client Name: _____

DOB:_____

Agency/Person to Exchange Information:

(Name)_ Brookings Behavioral Health & Wellness __

(Address-street)_____211 4th St_____

(city, state, zip)__Brookings, SD 57006_____

Phone#__(605)697-2850_____ Fax#__(605)697-2874_____

Fax transmission authorized, if needed? Yes ___ No _____

This information is requested for the following purpose:
□ Continuity of care
□ Application/reapplication for benefits
□ Disability determination
□ Chemical Dependency
□ Legal proceedings
□Other(specify):_____

Person making request: _____

Relationship:_____

Agency/Person to Exchange Information:

(Name)_____

(Address-street)_____

(city, state, zip)_____

Phone#_____ Fax#_____

Fax transmission authorized, if needed? Yes ___ No ____

The minimum necessary information to accomplish the purpose is:
□ Assessments □ Treatment Plan □ Session Notes
□ Labs □ Medications □ Referrals □ Form Completion
□ Provider Discharge □ Letter regarding:__
□ Other: _____

SERVICE DATES: _____

□ WRITTEN INFORMATION ONLY
□ VERBAL INFORMATION ONLY
□ WRITTEN, VERBAL AND ELECTRONIC INFORMATION

READ CAREFULLY

My signature below acknowledges my understanding of the following:

1. I understand that medical/behavioral health records are confidential. By signing this authorization I am allowing the release of information, including any substance abuse information, to the agency or person specified above. Transfer of the information released above to persons or agencies not specified is prohibited by law.
2. I understand that signing this authorization is not a condition of receiving treatment here.
3. This authorization includes both information presently compiled and information to be compiled during the course of the client's treatment at this agency.
4. This consent is subject to revocation by the undersigned at any time by completing the notice of revocation at the bottom of the page.
5. This consent to release information (unless revoked earlier) will automatically terminate one year from the date of signing, or twelve months from the date of signing if the purpose is for other than treatment.
6. Specify any special conditions, date, events that would result in revocation: _____
7. I understand that I have the right to receive a copy of this authorization and to request to see or copy the information disclosed.

Patient Signature: **Date:**

_____

Parent/Guardian/Legal Representative Signature: **Date:**

_____

Witness signature: **Date:**

_____

Notice of Revocation- This revocation cancels my authorization given above

Patient Signature:
_____ Date:_____

Parent/Guardian/Legal Representative Signature:
_____ Date: _____

Brookings Behavioral Health & Wellness cannot guarantee the recipient will not redisclose health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a consumer in a federally-assisted alcohol program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part2).