Restoration Counseling and Consulting, Inc.

Client Name: ______________________________ Birthdate: _________________________

CONSENT TO RELEASE MENTAL HEALTH, ALCOHOL AND DRUG ABUSE, AND/OR MEDICAL PATIENT RECORDS AND INFORMATION

Fill in all the blanks below

1. I authorized disclosure of records/information between:

Restoration Counseling and Consulting, Inc. and
6809 S Minnesota Ave, Suite 103
Sioux Falls, SD, 57108
Phone: (605) 838-9655
Fax: (605) 271-2548

Name ___________________________
Address ________________________
City, State, Zip___________________
Phone __________________________
Fax _____________________________

2. I authorize Restoration Counseling and Consulting, Inc. to release to, and/or request and receive the information as described below (check as many as apply):

Information	To be Released by Restoration Counseling	Requested by Restoration Counseling and Consulting, Inc.
Medical History	____________	____________
Physical Exam/Lab results	____________	____________
Brief Summary of Treatment progress and attendance	____________	____________
Chemical Use Assessment	____________	____________
Discharge Summary	____________	____________
Other (please specify)	____________	____________

3. This protected health information is being used or disclosed for the following purposes:

____

☐ The client has requested this information be used and disclosed but does not wish to specify the purpose for this release.

NOTICE TO RECEIVING THERAPIST/FACILITY: You may not re-disclose any of this information without express written consent of the client.

- I authorize the parties named above to speak by telephone regarding the information identified above.
- In consideration of this consent, I release the source of the records as identified above from any and all liability arising from their release in good faith.
- I understand that the releasing agency has no control over the security practices of the recipient(s).
- I understand that I may revoke this consent at any time in written form, except to the extent that action has already been taken. This consent will automatically expire one year from the date on which it is signed.

Client Signature: ______________________________________ Date: ___________________

Parent/guardian: _______________________________ Witness: ______________________