ALPINE
*counseling services, llc*

## AUTHORIZATION

For the use and/or disclosure of health information

Client / Patient Identification

Name:_____Date of Birth:_____

Phone:_____ Type (cell/home/work):_____

Address:_____

City/State/Zip:_____

Maiden/Previous Names:_____

Provider Information

Provider:_____

Alpine Counseling Services, LLC
510 Main Ave Suite 1
Brookings, SD 57006

Information Use:

☐Disclose to

and/or

☐Receive From

Name/Facility:_____

Address:_____

City/State/Zip:_____

Phone:_____Fax:_____

Information to be Disclosed and/or Received:

☐Evaluation ρTreatment Summary

☐Psychological Testing ρCourt / 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 Alpine Counseling 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.