WellSpring Therapy Center
4301 W 57th St Ste 100
Sioux Falls, SD 57108
605 335-1516
FAX 605 731-0896

CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Patient _____ Date of birth _____

Hereby authorize _____

To release/exchange (circle appropriate action) information contained in my client records to the following individual(s) and/or organization, and only under the conditions listed below:

1. Name of person(s), organization, address to whom disclosure/exchange is to be made

_____

_____

_____

_____

Attention _____

2. Specific type of information to be disclosed/exchanged:

- ❑ Diagnosis
- ❑ Attendance
- ❑ Progress
- ❑ Prognosis
- ❑ Drug/Alcohol History
- ❑ Mental Status Exam
- ❑ Physical Examination
- ❑ Mediation
- ❑ Treatment Summary
- ❑ Recommendations
- ❑ Discharge Summary
- ❑ Home Study
- ❑ Psychological/Social/Psychiatric Evaluation
- ❑ Other _____

3. The purpose and need for such disclosure/exchange is:

- ❑ Continuity of Treatment
- ❑ Aftercare Planning
- ❑ Referral
- ❑ Family Involvement
- ❑ Coordination of treatment services with above named provider
- ❑ Facilitate legal representation regarding _____
- ❑ Other _____

I understand that I may revoke this consent at any time, except to the extent that action has already been taken. I understand further, that this consent expires upon fulfillment of the above stated purpose, or six (6) months after the signature date, which ever comes first.

Client Signature _____ Date _____

Parent or Legal Guardian _____ Date _____

As of this date, I hereby revoke the consent provided on this authorization form.

Signature _____ Date _____

A copy of this release shall be valid as the original.