

CONSENT FOR INFORMATION DISCLOSURE

I, _____, hereby authorize the exchange of information between _____ and the SD DEPARTMENT OF SOCIAL SERVICES, DIVISION OF COMMUNITY BEHAVIORAL HEALTH and the **re-disclosure** of that information by _____ and the SD Division of Community Behavioral Health to:

- _____ DSS Division of Medical Services for Medicaid information
- _____ South Dakota Foundation for Medical Care for PRTF Admission
- _____ South Dakota Department of Health
- _____ DSS Division of Correctional Behavioral Health
- _____ South Dakota Department of Corrections or Juvenile Corrections Agent _____
- _____ Unified Judicial System or Court Services Officer, _____
- _____ My parents and/or legal guardian and/or prospective foster parents _____
- _____ Mountain Plains Research for purpose of reporting required demographic informatio}
- _____ Law Enforcement Officials (City and/or County)
- _____ My current and/or former educational institution for purpose of obtaining academic information
- _____ The designated accredited alcohol and drug treatment provider and/or funding source necessary to facilitate my entry _____
- _____ into chemical dependency treatment or services.
- _____ Physician, IHS, and/or Medical Clinic/Facility _____
- _____ Other _____
- _____ Other _____

Purpose of and need for the disclosure is to inform the person(s) or agency(ies) listed above of my:

- Treatment Needs Assessment and DSS Approval Form
- Diagnosis and Treatment Recommendations
- Eligibility for treatment services
- Financial Information and Funding Sources
- Medical, dental, and/or eye care information and/or eligibility
- Treatment Plan and/or Continued Care Reviews
- Attendance, cooperation, and progress in treatment
- Discharge Summary and/or Aftercare Plans
- Group data for reports to evaluate outcome of treatment
- Education Information
- Legal Information
- Other (be specific): _____

The above information will be used for the following: To provide the above noted individuals with information requested as noted above, about the individual named above, to coordinate all available information to ensure placement in the appropriate level of care, to ensure adequate funding, determine the diagnosis, course of treatment, follow-up, or need for other services, to ensure a full continuum of care and to ensure quality services.

I understand that some or all of this information may at times be communicated via electronic transmission.

I also understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in reliance on it, by signing the revocation section of my copy of this form and returning it to _____ at _____. In any event, this consent will expire automatically as follows:

.....One year after this consent form is signed OR

(Specification of the date, event or condition upon which this consent expires)

I also understand that my alcohol and/or treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F. R. Pts. 160 & 164, and 42 U.S.C. §§ 290 dd-2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that recipients of this information may redisclose it only in connection with their official duties.

Dated: _____ Client Signature: _____

Witness Signature: _____

REVOCATION SECTION

I hereby revoke this consent

(Signature)

(Date)