# CONSENT FOR INFORMATION DISCLOSURE

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

____DSS Division of Medical Services for Medicaid information
____South Dakota Foundation for Medical Care
____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 information
____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:** _____

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REVOCATION SECTION I hereby revoke this consent

_____ _____

(Signature) (Date)