State of South Dakota

CONSENT FOR RELEASE OF INFORMATION

I hereby give my consent to release the information described below **about**:

Patient/Participant Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone # _____

To the following person(s)/entities:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

From the following person(s)/entities:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip: _____

INFORMATION REQUESTED AND PURPOSE OF DISCLOSURE

☐ Medical/Clinical ☐ Demographic/Financial ☐ Business/Proprietary ☐ Adult ☐ Juvenile ☐ Other

☐ Other Specific Information Requested: _____

☐ Specific dates for Information Requested: _____ to _____

☐ Purpose for Disclosure: _____

I understand the information received may include information relating to drug and/or alcohol abuse or physical/sexual abuse. South Dakota State Agencies, their employees, officers, and medical providers are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

As stated in State Agency Notice of Privacy Policies, this consent form may be cancelled at any time except to the extent the staff have taken action upon it. If not cancelled, this consent to release information will terminate in **one year** or upon the following specified date: _____. I understand that this authorization may be revoked at any time, as long as I do so in writing.

I understand if this information is released to a third party, the information may be released by the person or entity that receives the information and may no longer be protected by federal or other applicable privacy regulations. Exception -- drug and/or alcohol information may not be redisclosed without consent.

I understand that my eligibility for, or enrollment in, State Agency Programs will not be based on whether I sign this consent form. Consent form complies with HIPAA provisions and must be signed.

_____ _____

Signature of Participant/Patient or Parent/Guardian Giving Consent Date

_____

Print Name Relationship to Participant/Patient

_____

Witness Signature Witness Name (print) and Relationship to Participant/Patient

_____

Telephone number of the participant/patient for verification of the request for information

I cancel this request to release information effective immediately:

_____

Signature Date