Journey Counseling Services, LLC
6209 S Pinnacle Pl, Suite 102
Sioux Falls, SD 57108
Phone: 605-988-8131
www.journeycounselingservices.com

CONSENT TO RELEASE OR OBTAIN INFORMATION

This is a consent for release of information about: _____
(Client Name)

Birth Date: _____

I authorize _____ of Journey Counseling Services, LLC to release to or

obtain information from: _____
(Name of persons or organizations)

Address: _____

Phone: _____ Fax: _____

For the purpose of: _____

- I understand that unless noted this release shall be reciprocal, allowing both Journey Counseling Services, LLC and the person or entity noted above to receive and exchange information.
- I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations if the person or entity is not a health care provider or health insurer.
- I understand that my written notice to Journey Counseling Services, LLC will revoke this consent at any time.
- I understand that information regarding my care may be shared internally to assure effective services.
- I understand that unless otherwise noted this release can be transmitted electronically.

THE INFORMATION WILL BE USED/DISCLOSED FOR THE FOLLOWING PURPOSES:

- ❑ Acknowledgement of Referral
- ❑ Past/Current Assessment
- ❑ Diagnostic Information
- ❑ Case Management
- ❑ Legal Orders/Filings
- ❑ Progress
- ❑ Social/Historical Past/Current
- ❑ Recommendations/Plans
- ❑ Medical/Medication
- ❑ Community Support
- ❑ Discharge Summaries

Other (specify): _____

This authorization expires on: _____

Client: _____

_____ _____
(Signature) *(Date)*

Parent/Guardian/Representative: *(If client is unable to give legal consent.)*

_____ _____
(Printed Name) *(Relationship)*

_____ _____
(Signature) *(Date)*