WEST RIVER
MENTAL HEALTH

350 Elk St
Rapid City, SD 57701
605-343-7262

111 North St
Rapid City, SD 57701
605-343-0650

623 Dahl Road
Spearfish, SD 57783
605-642-2777

Canyon View Circle #3
Hot Springs, SD 57747
605-745-6222

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION

Client Information

Client Name: _____ **DOB**: _____

Client ID: _____ **Effective Date**: _____

General

West River Mental Health, Inc. abides by all federal and state confidentiality laws including HIPAA (Health Insurance Portability & Accountability Act), and 42 C.F.R Part 2. By signing this authorization, I acknowledge, accept, and agree. This information has been disclosed to you from records in which confidentiality is protected by federal law. Federal Regulations (42 CFE Part 2) Prohibit the recipient from making any further disclosure of it without the specific written consent of the person whom it pertains or except as otherwise permitted by suds regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Information disclosed under 42 C.F.R. Part 2 cannot be used to criminally investigate or prosecute any client with a SUD except at provided for in 42 CFR Section 2.

Release To / Release From

Name or Other Specific Identification of Person(s) authorized to receive/make the requested use or disclosure:

◯ Organization/Provider: ◯ Contact **Type:** ☐ Release To ☐ Obtain From

Release To/From: _____

Contact Type: _____

Organization: _____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax Number:** _____

Expiration

If nothing marked- one (1) year from date signed

☐ 1 time disclosure ☐ 6 months ☐ End of Agency Treatment

Start Date: _____ End Date: _____

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Information to be Used or Disclosed

The information that can be disclosed under this authorization includes the following, if available

ROI Type: ☐ General ☐ MH ☐ SUD

☐ Acknowledgement/ Attendance/ Participation of of Treatment	☐ Billing/Insurance/Financial Information	☐ Diagnosis
☐ Discharge Summary/Plan	☐ Intake/Admission Information	☐ Legal Document
☐ Medical History, Lab Results, Immunizations Records	☐ Medications Prescribed	☐ Progress Notes
☐ Progress Review/Summary	☐ Psychiatric/Psychological Evaluation(s)	☐ School Records/Reports/IEP's
☐ Screening Assessment(s)	☐ Treatment/Care Plan(s)	☐ Other

Other: _____

_____

_____

Restrictions

Terms

- Under the state and federal confidentiality provisions only the information specified can be released.
- West River Mental Health, Inc. cannot ensure the recipient will maintain the confidentiality of the mental health and/or SUD information authorized and released. If the person or organization obtaining this information is not a health care providers, health plan or covered under the federal privacy regulations, the information may no longer be protected by federal privacy laws including 42 C.F.F. Part 2 and could be re-disclosed.
- This authorization will be honored unless revoked in writing. Revocation may be made at any time except to the extent action has already been taken.
- Persons or organzations may not re-disclose substance abuse treatment information.
- This authorization will expire in one (1) year from the date of signature, or 90 days from the date of discharge from the agency unless one of the following is selected. 30 days, 60 days, 90 days.
- This authorization is voluntary. I have been given the chance to ask questions and receive answers pertaining to this document.
- A list of entities to which my information has been released can be provided by West River Mental Health, Inc.

By checking these boxes, I agree that I have read, understand and agree to these terms.

☐ NOTICE TO CLIENT: NOTICE TO CLIENT Signing this form is voluntary and not required to receive services with West River Mental Health, Inc. I Understand.

☐ ACCESS TO MY RECORD: ACCESS TO MY RECORD: I understand I can request a copy of my record. This request will be reviewed and approved by my therapist. I understand I can also review my records with my therapist by making an appointment. This request can take 30 days to complete and charges will apply.

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Agency Contact Information

Program: _____ Attention: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Other

Copy Given to Client ◯ Yes ◯ Declined a copy Agency Staff: _____

ID Verfied By ☐ Driver's License ☐ Other Picture ID ☐ Known to Agency

Additional Information

Please note- The records released may contain alcohol and drug abuse information and/or information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

Alcohol/Drug Abuse:

◯ I authorize the release of information relating to referral and/or treatment for alcohol and drug abuse.

◯ I **PROHIBIT** the release of information relating to referral and/or treatment for alcohol and drug abuse.

HIV/AIDS/Sexually Transmitted Disease/Communicable Disease

◯ I authorize the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

◯ I **PROHIBIT** the release of information relating to HIV/AIDS/sexually transmitted disease/communicable disease.

Clinician/Witness: _____ **Signature Date: _____**

Client: _____ **Signature Date: _____**