PO Box 763
280 Main Street, Suite 14
Hill City, SD 57745
Office: 605.390.8791

403 National Street, Ste 1
Rapid City, SD 57702
Office: 605.390.8791

Authorization to Release Confidential Records and Information

A. Identifying information about me/the patient
Name: ____Date of birth: _____________
Current phone(s):________________________Address: _________________________
Name of parent/guardian (if applicable): _________________Phone #: ______________

B.I authorize Suzette Waswick Counseling Services, LLC the release of information described below (CHECK ONE):

RELEASE TO: ☐ RECEIVE FROM: ☐ EXCHANGE WITH: ☐

Person or organization:____

Address:____

Phone:_________________________________ Fax Number: ____________________________

C. The records to be disclosed are marked by an X in the boxes below. The items *not* to be released have a ling drawn through them. All episodes of care are to be included unless dates are indicated.

☐ Inpatient or outpatient treatment records for physical/medical and/or psychological, psychiatric, or emotional
☐ Illness Date(s) of inpatient or outpatient treatment _____________ to _____________
☐ Other identifying information about the service(s) rendered:_______________________
- ☐ Social, family, developmental histories
- ☐ Information about how the patient's condition affects or has affected his or her ability to complete tasks, activities of daily living, or ability to work
- ☐ Assessments with diagnoses, prognoses, and recommendations, and all similar documents.
- ☐ Academic or educational records
- ☐ Billing Records
- ☐ Scheduled appointments and attendance
- ☐ Medications
- ☐ Other records:________________________
- ☐ Emergency Contact

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D.I authorize the transfer of these records for the following purpose(s) or uses:

- ☐ Further mental health evaluation, treatment, or care
- ☐ Treatment planning
- ☐ Qualification for services or benefits
- ☐ Other:____

E.I authorize Suzette Wasvick Counseling Services, LLC to communicate my/the patient's authorized information by telephone, fax, mail, and/or face to face with the person and/or organization in section B. I understand that Suzette Wasvick Counseling Services, LLC has no control of the information after it has left the premises. I understand the consequences if I refuse to allow this release. My consent is fully voluntary. I understand that I may revoke this ROI authorization, but that doing this will not bring back the information that was released before the date of the revocation. I can do this at any time by writing to Suzette Wasvick Counseling Services, LLC. If I do not void or cancel this ROI authorization**, it will automatically expire 1 year from the date I signed it.**

F.I have had the provisions of this form explained to me and believe that I fully understand this ROI.

G. Signatures:

_______________________________ _______________________________ ___________

Signature of Patient Printed Name Date

_____________________________________ ____________________________________

Signature of parent/guardian/repetitive if needed Printed Name

______________________________________ _________________

Relationship Date