



Stronghold Counseling Services, Inc.

Client Name: _____ Birthdate: _____

CONSENT TO RELEASE MENTAL HEALTH, ALCOHOL AND DRUG ABUSE, AND/OR MEDICAL PATIENT
RECORDS AND INFORMATION
Fill in all the blanks below

1. I authorized disclosure of records/information about _____ between:

Stronghold Counseling Services, Inc. 625 South Minnesota Ave, Suit 201 Sioux Falls, South Dakota, 57104 Phone: (605) 334-7713 Fax: (605) 334-5348	and	Name _____ Address _____ City, State, Zip _____ Phone _____ Fax _____
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2. I authorize Stronghold Counseling Services, Inc. to release to, and/or request and receive from the about person(s)/agency the following information as described below (check as many as apply):

Information	To Be Released by Stronghold	Requested by Stronghold
Medical History	_____	_____
Physical Exam/Lab results	_____	_____
Social History assessment	_____	_____
Chemical history assessment	_____	_____
Psychological evaluation	_____	_____
Aftercare planning	_____	_____
Change in condition or status	_____	_____
Discharge Transfer Summary	_____	_____
Limited Report	_____	_____
Progress Reports	_____	_____
Other (specify)	_____	_____

3. This protected health information is being used or disclosed for the following purposes: _____

The patient has requested this information be used and disclosed but does not wish to specify the purpose.

4. This authorization will expire (insert date or event) _____. I understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it by sending written notification to **Dr. JC Chambers at the above address**. I understand this communication will reveal my presence as a client at a treatment facility.
I understand that if I refuse to sign this authorization I may not be eligible for, or receive research-related treatment or treatment that I have requested fro the purpose of disclosure to others.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Information sent : _____ Date: _____