FOOTSTEPS COUNSELING, LLC
PO BOX 1221
ABERDEEN, SD 57401
605-377-7570
www.footstepscounseling.weebly.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name _____ Date of Birth _____ Client Number _____

Footsteps Counseling LLC
PO Box 1221
Aberdeen, SD 57402
Phone 605.377.7570
Email: hhfootsteps@icloud.com

_____ Phone ( ) -
Agency/Program/Person

_____ Fax ( ) -
Address

_____
City State Zip

I,_____Authorize Footsteps Counseling, LLC to: ☐ To Disclose to: ☐ To Receive From

I understand that the specific type of information of my protected health information from my records to be disclosed (specify extent or nature of information to be disclosed):

☐ *Family and Social History* ☐*Medical History/Records* ☐*Treatment Plan/Progress* ☐*Diagnosis*
☐ *Discharge Summary/Plan* ☐*Substance Abuse Records* ☐*Educational Records* ☐ *Other: Specify* _____
☐ *Psychological Reports/Testing/Information* ☐*Group Progress: Specify Group* _____

I understand the information disclosed may include reference to treatment of alcohol/drug abuse or mental/behavioral and Protected Health Information. The purpose or need for this disclosure is: (check all that apply)

☐For Continuity of Services ☐Research ☐ Further Assessment, Treatment, or Care Coordination ☐For Supervision
☐To Fulfill Requirement of Purchaser/EAP ☐For the Purpose of Quality Assurance ☐Other: Specify _____

This authorization includes consent to release information verbally from these records ☐ ***Yes*** ☐ ***No*** ☐ ***Other*** _____I have been informed that I have the right to withhold my consent concerning release of Protected Health Information of confidential material relevant to me or the person named above. Expiration Date of this Authorization: If not previously revoked, this consent will terminate in one year ☐ ***After the Above information has been released*** ***OR*** ☐ ***On Specific Date or Event:*** _____

_____ _____
Signature of Client *Date*

_____ _____
Signature of Parent/Guardian/Legal Representative authorizing Disclosure *Date*

_____ _____ _____
Relationship to Client *Client Date of Birth* *Client Social Security Number*