Dakota Hope Counseling, LLC

1500 S. Sycamore Ave, Sioux Falls, SD 57110 | T 605-223-5155| DakotaHopeCounseling.com

Consent to Release or Obtain Information: For Individual, Couple, or Family Therapy Services (Case Collaboration)

This is a consent for release of exchange of information for collaboration for individual, couple, or family care. **Primary Client:** _____ **Birth Date:**_____

I authorize Michelle Pliska at Dakota Hope Counseling to release and exchange information with the following persons or organizations (Family Member, Medical Practitioner, Pastor, Community Resource, etc.):

_____

Address:_____ City:_____ State:___ Zip:_____

Phone:_____Fax:_____ Email:_____

For the purpose of: **Collaborative Client Care**

- I understand that I am authorizing Dakota Hope Counseling and those identified to release and exchange information The information I authorize a person or entity to receive may not be re-disclosed and no longer protected by federal privacy regulations.
- I understand that unless noted this please shall be reciprocal, allowing both Dakota Hope Counseling and the sources noted to receive and exchange information.
- I understand that my written notice Dakota Hope Counseling will revoke this consent at any time.
- I understand that I will be informed of requests for information.
- I understand that I may review any information being disclosed or a copy of the information used.
- I understand that information regarding my care may be shared internally to assure effective services.
- I understand that unless noted this release can be transmitted by facsimile.

This information will be used/disclosed for the following purposes:

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

This authorization is valid until revocation by client or until this date:_____

Client or Guardian Name:_____ Relationship to Client:_____

Client or Guardian Signature:_____ Date:_____