UNIVERSITY OF SOUTH DAKOTA
SANFORD SCHOOL OF MEDICINE

Center for Disabilities
Release of Information

Full legal name: _____**Date of Birth:**_____

Also known as: _____

I hereby authorize the following to release and/or exchange information from my Medical/Clinical/ Educational records as described below. I authorize release of the following information to the Center for Disabilities: medical evaluations and records, educational evaluations and records, and treatment records, including but not limited to progress notes, therapy notes, report cards, evaluation reports, IEP, IFSP, IHP.

Organization or person allowed to receive and/or exchange information as indicated by this form:

Center for Disabilities Sanford School of Medicine of The University of South Dakota 1400 W. 22nd Street Sioux Falls, SD 57105 Phone: 800-658-3080 (V/TTY) Fax: 605-357-1438	AND	Sanford Health Systems Sanford Children's Specialty Clinic 1600 W. 22nd Street Sioux Falls, SD 57105 Phone: 605-312-1000

Organization(s) or Person(s) allowed to release and/or exchange my health information as indicated by this form:

Hospital of: Birth _____
(Hospital Name)

Address _____
(street) (city/state) (zip)

Phone _____ Fax _____

Medical: Doctor and/or Clinic _____
(Doctor's First Name) (Doctor's Last Name/Clinic Name)

Address _____
(street) (city/state) (zip)

Phone _____ Fax _____

Psychiatric/Psychological: Doctor and/or Clinic _____
(Doctor's First Name) (Doctor's Last Name/Clinic Name)

Address _____
(street) (city/state) (zip)

Phone _____ Fax _____

This information shall include: **You must initial only those items that apply:**

___Psychiatric Evaluations
___Psychiatric Treatment Notes
___Psychological Evaluations
___Psychological Treatment Notes
___Psychotherapy Evaluations
___Psychotherapy Notes
___Other _____
___All of the above
___Exchange information ONLY verbally

School: School _____

Address _____
(street) (city/state) (zip)

Phone _____ Fax _____

School: School _____

Address _____
(street) (city/state) (zip)

Phone _____ Fax _____

Other: Agency or Other_____

Address _____
(street) (city/state) (zip)

Phone _____ Fax _____

Other: Agency or Other_____

Address _____
(street) (city/state) (zip)

Phone _____ Fax _____

Other information regarding signature of this form:

- **I understand that the Center for Disabilities will send records** via mail services and if necessary, may transmit records by fax or other electronic means to organizations or persons indicated by this form.
- **The information to be disclosed** will assist the Center for Disabilities staff in providing evaluation and/or consultation services for the individual for whom records are being requested.
- **I understand this authorization is voluntary** and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.
- **I understand that I may revoke this authorization** at any time by written notification to the Center for Disabilities. However, the revocation is not valid if: (a) action was previously taken in reliance on this authorization; or (b) this authorization is obtained as a condition for obtaining insurance coverage; other laws provide the insurer with the right to contest a claim under the policy or the policy itself.
- **I understand that the information in my health record** may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- **I understand that if the person or entity that receives the above information** is not a health care provider or plan covered by federal privacy regulations, the information may no longer be protected by federal privacy regulations.
- **I understand disclosure of this information** may carry the potential for unauthorized re-release and the information may not be protected by federal privacy regulations.
- **I understand that a photocopy of this form** shall have the same force and effect as the original.
- **I hereby release** the Center for Disabilities from all legal responsibility that may arise from the act I have authorized above.

If individual being referred is 18 years old or older, he/she must sign the Release of Information him/herself unless guardianship has been established by the parent or another individual. If guardianship has been established for the individual being referred, please include a copy of the guardianship papers.

_____

Patient Name (Please Print)

_____	_____	_____
SS#	Date of Birth	Phone Number

_____	_____
Signature of Patient or Personal Representative	Date

_____	_____
Personal Representative	Relationship

_____	_____
Organization Representative	Patient ID Number

This authorization will automatically expire one year from the date signed by my signature, unless I indicate an earlier expiration date here: _____.

PLEASE INCLUDE COPY OF LEGAL GUARDIANSHIP PAPERS IF GUARDIANSHIP HAS BEEN ESTABLISHED FOR THIS INDIVIDUAL

To the agency/ source releasing records – please send records to Center for Disabilities at 605-357-1438. If you do not have any records on this individual, please contact the Center for Disabilities at 800-658-3080 or return this form indicating you have no records.