

MIDWEST HEALTH MANAGEMENT SERVICES, LLC
SOUTH DAKOTA HEALTH PROFESSIONALS ASSISTANCE PROGRAM
3130 West 57th Street Suite 111
Sioux Falls SD 57108
Tel: (605) 275-4711 Confidential Fax: (605) 275-4715

AUTHORIZATION AND CONSENT TO RELEASE INFORMATION

I, _____, _____ authorize
Name *DOB*

SD Health Professionals Assistance Program
Name of individual/program

to disclose to and communicate per mutual unrestricted release of information

Name and contact information of individual/program

Mutual release to include the following information:

Mutual unrestricted release of information

- Complete Treatment Needs Assessment/Evaluation Findings (mental health or SUD)
- Discharge Summary (mental health or SUD)
- Continued Care Recommendations (mental health or SUD)
- Psychiatric/Psychological Records
- HPAP Participation Agreement
- Urine Drug Screen/ Toxicology Reports
- Worksite monitoring
- Medical records/lab results
- Legal Records
- Other _____

I understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on it, and that in any event this consent expires automatically as follows:

Duration of HPAP involvement
Date/Event/Condition

Participant Signature

Date

Witness Signature

Date

This information is released subject to the Confidentiality Provision of Federal Law. Federal regulations (42 CFR, Part 2) prohibit any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute the patient.