(Optional)

Embark Mental Health

3240 E Bison Trail, Suite 200
Sioux Falls, SD 57108
P: (605) 961-4746 **F:** (605) 961-4747

Name: _____ Date of Birth: _____

CONSENT TO RELEASE MENTAL HEALTH, ALCOHOL AND DRUG ABUSE, AND/OR MEDICAL PATIENT RECORDS AND INFORMATION

1. I authorized disclosure of records/information between:

Embark Mental Health
3240 E Bison Trail, Suite 200
Sioux Falls, SD 57108
Phone: (605) 961-4746
Fax: (605) 961-4747

and

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

2. I authorize Embark Mental Health, LLC to release to, and/or request and receive the information as described below (check as many as apply):

Information:	**To Be Released by Embark Mental Health**	**Requested by Embark Mental Health**
Medical History		
Physical exam/lab results		
Brief summary of treatment progress and attendance		
Substance use assessment		
Discharge Summary		
Progress Notes		
Other (please specify)		

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

_____

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

NOTICE TO RECEIVING THERAPIST/FACILITY: You may not re-disclose any of this information without express written consent of the client.

- I authorize the parties named above to speak by telephone regarding the information identified above.
- In consideration of this consent, I release the source of the records as identified above from any and all liability arising from their release in good faith.
- I understand that the releasing agency has no control over the security practices of the recipient(s).
- I understand that I may revoke this consent at any time in written form, except to the extent that action has already been taken. This consent will automatically expire one year from the date on which it is signed.

Client Signature: _____ Date: _____

Parent/guardian: _____ Witness: _____