AUTHORIZATION FOR RELEASE OF FINANCIAL INFORMATION

RE: Name _____

Social Security Number _____

Birth Date _____

Address _____

_____

County of Residence _____

I hereby authorize any individual, agency, institution, facility, financial institution, insurance company, asset holder, debtor, creditor, or other providers of financial services where my accounts may be located to supply financial information or any information relating to my accounts to Lake County concerning myself and/or my family and to allow inspection and reproduction of records. I further authorize the county to release such financial information to providers or cooperating state or federal agencies.

I hereby release all individuals, agencies, institutions, facilities, financial institutions, insurance companies, asset holders, debtors, creditors, or other providers of financial services where my accounts may be located from any and all liability because of compliance with this authorization and the release of such information.

This authorization is given only in connection with its use by Lake County in the administration of its programs under the provisions of SDCL chapters 28-13, 28-13A, and 28-14. I understand that this information will be considered confidential and shared only with individuals, agencies, institutions, or facilities assisting with my financial needs.

A photocopy of this release shall be as valid as the original.

I understand that this authorization may be revoked by me in writing at any time before my records are disclosed, and that this authorization is valid for no more than three (3) months from the date of my signature.

Dated this _____ day of _____, _____.

_____
Patient's Signature

_____
Spouse's Signature

_____
Spouse's Social Security Number

_____

Signature of parent, guardian, spouse, or authorized representative if patient is either a minor or incapacitated

_____

Relationship to Patient

_____

Parent/guardian/spouse/authorized representative SSN