AUTHORIZATION FOR RELEASE OF INFORMATION

RE: Name _____

Social Security Number _____

Birth Date _____

Address _____

_____

County of Residence _____

I am an applicant for financial assistance from Lake County. In order for Lake County to develop an adequate record and file pertaining to my eligibility and suitability to qualify for services under the laws, rules, regulations and procedures of such agency, I hereby authorize any individual or agency of any nature to release and furnish to Lake County any information they have in their files regarding my physical, mental, academic, psychological, drug or alcohol abuse, social and economic condition.

I hereby release all individuals, agencies, institutions, or facilities 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 one (1) year 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