Aspen
Counseling Services, PLLC
1019 6th Ave SE, Watertown, SD 57201
Phone: (605) 878-0606 Fax: (605) 878-0214

## *Authorization to Release/Request Information*

**Patient's Name** _____ **Date of Birth**_____

I authorize Aspen Counseling Services, PLLC to release and/or request my health information to the person or organization designated below.

Name _____

Address _____

City, SD _____ Zip _____

Phone _____ Fax _____

Name _____

Address _____

City, SD _____ Zip _____

Phone _____ Fax _____

I understand that I have the right to cancel this authorization by sending written notification to Aspen Counseling Services, PLLC. However, I understand my cancellation will not be effective to the extent that Aspen Counseling Services, PLLC has already taken action regarding the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that the recipient of this information may re-disclose it and that the information will no longer be protected by the HIPAA Privacy Rule. I understand that my clinician generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

_____ _____

**Signature of Patient or Guardian** **Date**