AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

DATE NEEDED BY: ______________________ PLEASE CHECK ONE: ☐ To Be Picked Up ☐ To Be Mailed ☐ To Be Faxed

401 9th Avenue NW, PO Box 170, Watertown, SD 57201
Phone: 605-882-2630 Toll-Free: 1-800-658-4763 Fax: 605-882-0447

PATIENT NAME: ____
(LEGAL LAST, FIRST, MIDDLE)

DATE OF BIRTH: ______________________ HEALTH RECORD #: ______________________

1.) I authorize the use or disclosure of the above named individual's health information as described below.
2.) The Health Care Facility/Provider who has information you would like to release?

FACILITY NAME: ______________________ FACILITY FAX #:______________________

ADDRESS: ____
(STREET, PO BOX, CITY, STATE, ZIP)

3.) The type and amount of information to be used or disclosed is as follows:
(Include dates where appropriate.)

☐ Physician Clinic Notes ☐ X-ray Reports
☐ X-rays ☐ Entire Record

4.) To whom should the information be sent?

FACILITY NAME: ____

ADDRESS: ____
(STREET, PO BOX, CITY, STATE, ZIP)

5.) I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Health Information Management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ______________________.
If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

6.) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthroized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact Karen Brandriet - Medical Records Supervisor.

SIGNATURE: ____ DATE: ______________
(OF PATIENT OR LEGAL REPRESENTATIVE)

RELATION TO PATIENT: ____
(IF SIGNED BY LEGAL REPRESENTATIVE)

SIGNATURE OF WITNESS: ____