

Authorization for the Use or Disclosure of Protected Health Information Records

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Surgical Institute of South Dakota, P.C. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your written authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION SECTION (Please print)

Patient Name: _____

Address: _____

Phone: _____

Date of Birth: _____ Social Security #: _____

RECORDS RELEASED FOR THE FOLLOWING PURPOSE (Please check one)

- Another Doctor's Office
- Worker's Comp/Disability
- Self
- Other (Please Specify) _____

I AUTHORIZE THE RELEASE OF INFORMATION FROM THE FOLLOWING

Name: _____

Address: _____

Phone: _____

Fax: _____

I AUTHORIZE THE RELEASE OF INFORMATION TO THE FOLLOWING

**Surgical Institute of South Dakota, P.C.
911 East 20th Street Suite 800
Sioux Falls, SD 57105-1050
Phone: (605) 334-0393
Fax: (605) 334-6028**

TYPE OF INFORMATION REQUESTED (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Consults | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Operative Notes | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> Vascular Reports |
| <input type="checkbox"/> Miscellaneous Reports | <input type="checkbox"/> All Records |
| <input type="checkbox"/> Other (please specify) _____ | |

Date of span of requested records (if known) _____

METHOD OF RELEASE OF INFORMATION AND WHEN NEEDED BY (Please check one)

- Mail records on or before _____
- Fax records on or before _____
- Patient will hand carry records on _____

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to Surgical Institute of South Dakota, P.C. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that this authorization will automatically expire one year from the date of this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not. I understand that I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

Signature Date

Printed Name Relationship if not patient

REVOCATION SECTION

I hereby revoke this authorization.

Signature Date

FOR OFFICE USE ONLY

Date Received: _____ Date Sent: _____ By: _____