Surgical Institute of South Dakota

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.

PATIENT IDENTIFICATION

Name: _____ Date of Birth: _____
Address: _____ Phone: _____
City/State/Zip: _____
Maiden/Previous Names/Nickname: _____
Social Security Number: _____

I AUTHORIZE THE RELEASE OF INFORMATION FROM

Provider/Facility Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

DISCLOSE TO

Facility Name: **Surgical Institute of South Dakota** **Attention:** _____
Address: **911 E. 20th Street, Suite 700**
City/State/Zip: **Sioux Falls, SD 57105**
Phone: **605-334-0393** Fax: **605-334-6028**

INFORMATION TO BE DISCLOSED

__Clinic Progress Notes __Operative Reports __Hospital Reports
__Radiology Reports __Lab/Pathology Reports __Other (please specify)_____
__All Records

SERVICE DATES

Dates of service from (date) _____ to (date) _____

PURPOSE OF DISCLOSURE

__Continued Medical Care __Self __Other (please specify)_____

EXPIRATION DATE

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 shall be in effect for 1 year from this date, for records generated as a result of service.

METHOD OF RELEASE OF INFORMATION & WHEN NEEDED BY

__Fax __Mail __Patient pick-up

Records needed on or before_____

AUTHORIZATION

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 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 of Patient or Legal Representative Date

_____
Printed Name Relationship if not patient

REVOCATION

BY SIGNING BELOW I REVOKE THIS AUTHORIZATION.

_____
Signature of Patient or Legal Representative Date

MEDICAL RECORDS USE

Date Received: _____ Date Sent: _____ By: _____