AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Today's Date: ____________ **Date Needed by:** ____________	Paper **OR** CD	Fax Email Mail Pick Up at: Black Hills Surgical Hospital Black Hills Imaging Center Lombardy Business Office

PATIENT INFORMATION

Name:	**Date of Birth:**	
Address:	**Phone:**	**Cell:**
City/State/Zip:	**Email Address:**	
Maiden/Previous Names/Nickname:		

OBTAIN INFORMATION FROM:

Provider/Faculty Name: BLACK HILLS SURGICAL HOSPITAL & IMAGING CENTER	
Address: 1868 LOMBARDY DR.	**Phone:** (605) 721-4900
City/State/Zip: RAPID CITY, SD 57703	

DISCLOSE INFORMATION TO:

Name/Facility:	
Address:	**Phone:**
City/State/Zip:	**Fax:**

INFORMATION TO BE DISCLOSED

Dates of Treatment: __________ through __________ ; **OR** All Dates

Entire Record Operative Report History & Physical Exam Discharge Summary Billing Records

Progress Notes Path/Lab Report Consultation Report Imaging Study CD (CT/MRI/XR)

Imaging Reports ****Have the results of imaging scan(s) been reviewed with you by the referring provider?** YES NO
If "Yes", results will be available immediately. If "No", results will be available within 30 days. If the patient calls back to inform us the physician has gone over the results of their imaging with them, the results may be released immediately.

PURPOSE OF DISCLOSURE

Continuing Medical Care Legal Out of town move School Military Insurance Claim
Consult/Second Opinion Personal Employment Other (Specify)______________________

EXPIRATION DATE: This authorization will expire one year from the date of signature **OR** On this date: _______________.

REVOCATION

I understand that I may revoke this authorization at any time by sending a written notice to BHSH Health Information Management Department at: 1868 Lombardy Dr., Rapid City, SD 57703. However, the revocation is not valid if (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage. Other law provides the insurer with the right to contest a claim under the policy or the policy itself.

AUTHORIZATION

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "DISCLOSE INFORMATION TO." I understand that the information to be released may include information regarding behavioral and mental health services, psychiatric care, treatment for drug and alcohol abuse, sexually transmitted diseases, and HIV and/or AIDS related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits. I understand the BHSH/BHIC has the right to charge a reasonable cost based fee for reproduction and mailing of my medical records, unless it's for continuing medical care.

Signature of patient/parent/personal representative	**Date**
(Relationship to patient, if signed by parent/personal representative)	*Please supply proof of authority to act.*

Date released:____________	**Released by:**_________	**Comments:**____