BLACK HILLS SURGICAL HOSPITAL

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Complete this document or Visit the BHSH website to Access the Patient Portal
Call 605-721-4969 for further assistance. www.bhsh.com

Today's Date _____ Date Needed by: _____ Acct completed on: _____

PATIENT INFORMATION

Name: _____	Date of Birth: _____
Address: _____	Phone: _____ Cell: _____
City/State/Zip: _____	Email Address: _____

Maiden/Previous Names/Nickname: _____ FAX: _____

OBTAIN INFORMATION FROM:

Provider/Facility Name:	BLACK HILLS SURGICAL HOSPITAL & IMAGING CENTER	
Address:	216 Anamaria Drive	Phone: (605)721-4969
City/State/Zip:	RAPID CITY, SD 57701	Fax: (605)721-4948

DISCLOSE INFORMATION TO:

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

Release Format - If none of these formats work, please call our HIM department at 605-721-4969

1. ☐ Paper via ☐ Mail OR ☐ Fax **2.** ☐ Electronic via ☐ Email OR ☐ Push Images

INFORMATION TO BE DISCLOSED

Dates of Treatment: _____ through _____ ; **OR** ☐ All Dates

☐ Entire Medical Record	☐ Operative Report	☐ Discharge Summary
☐ History & Physical Exam	☐ Billing Records	☐ Progress Notes
☐ Imaging Study (CT/MRI/XR)	☐ Path/Lab Report	☐ Consultation Report
☐ Pain Clinic Notes	☐ Imaging Report	☐ Other: _____

PURPOSE OF DISCLOSURE

☐ Continuing Medical Care ☐ Legal ☐ Insurance Claim ☐ Consult/Second Opinion ☐ Personal

☐ Other (Specify) _____

REVOCATION

I understand that I may revoke this authorization at any time by sending a written notice to BHSH Health Information Management Department at: 216 Anamaria Drive, Rapid City, SD 57701. 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 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 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.

This authorization expires one year from the date of my signature unless I specify a different event, purpose or alternative expiration date here: _____

_____ _____

Signature of patient/parent/personal representative **Date**

_____ _____

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

BHSH Health Information Management, 216 Anamaria Drive,Rapid City, SD 57701 (P)605-721-4969 (F)605-721-4948

Date released: _____ Released by: _____ Comment ☐

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