AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A. Patient Identification (Please Print)

Full Name: ______________________________ Date of Birth: ____ / _____ / ________

Address: ______________________________ City: ______________________

State: _______________ Zip: _______________ Telephone: ______________________

B. Information to Be Used and Disclosed

Records to be Disclosed From: Black Hills Surgical Hospital, 216 Anamaria Dr. Rapid City, SD 57701

Date of Service Period: From: _______________(*date*) to: _______________(*date*)

Records to be Released *(Please check only those which apply)*:

☐ Operative Report ☐ Discharge Summary ☐ History and Physical ☐ Imaging Reports (MRI/CT/X-Ray)
☐ Injection/Pain Clinic Reports ☐ Lab/Path Results ☐ Physician Progress Notes ☐ Physician Orders
☐ Itemized Bill ☐ UB04 / HCFA1500 ☐ Diagnostic Films/Images ☐ Complete Medical Record
☐ Other, (please be specific): ______________________________

Substance Use Disorder Information. I understand that if my records contain substance use disorder information which are protected by federal law, then those records will not be included unless I consent by initialing this section. I understand that without my consent federal regulations may prevent the release of these records despite my directions. Information will be disclosed to the person identified in Section C below if I consent.

Initial one

___Include ___Do Not Include

C. Send/Release Information To (Please Print)

Name: ______________________________ *"Self" not accepted. Please complete section.*

Address: ______________________________

City:______________________________ **State**: ___________ **Zip**:_______________

Phone: ____________________ **Fax**: ____________________ **Email**: ____________________

Delivery Method (select one): ☐ Mail ☐ Fax ☐ Email ☐ Pickup at BHSH / BHIC (circle one) ☐ Push Images

D. Authorization and Consent

By signing below, I acknowledge, agree, and understand the following:

- **Right to Revoke**. Except to the extent action has already been taken in reliance on this Authorization, I can, at any time, revoke this Authorization by submitting a notice in writing.
- **Expiration Date**. Unless revoked, this Authorization will expire twelve (12) months from the date it is signed.
- **Re-Disclosure**. Information used and/or disclosed pursuant to this Authorization will not be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and some information may also be re-disclosed by the recipient, unless otherwise prohibited by law.
- **Not Required**. I do not have to sign this Authorization, and my treatment will not be denied if I do not sign this form.

I hereby authorize and instruct **Black Hills Surgical Hospital** to disclose my protected health information as listed in the above Section B to the person/entity identified in the above Section C.

______________________________ ______________________________
Signature **Date**

E. Legally Authorized Representative (If Applicable)

If you have signed as the legally authorized representative of the individual identified above, please provide documentation supporting your authorization and complete the following:

Legally Authorized Representative Name (Printed): ______________________________

Relationship to Patient: ______________________________

Description of Authority to Act for Individual: ______________________________