Sponsored by the Benedictine and Presentation Sisters

Avera St. Luke's

305 South State Street
Aberdeen, SD 57401
(605) 622-5000

www.averastlukes.org

Medical Record #_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name _____ Birthdate _____

Maiden/Other Name _____ Social Security # _____

I hereby request and authorize:

Name of Facility/Person _____

Address _____

To release information from my health record to:
Name of Facility/Person _____

Address _____

Please release the following information:

Dates of Service _____

___ Discharge Summary	___ Operative Report	___ X-ray Report
___ History & Physical	___ Emergency Report	___ EKG Report
___ Consultation	___ Laboratory Report	___ Pathology Report
___ Other (specify) _____		___ Entire Record

All records pertaining to drug or alcohol abuse records will not be released unless specifically authorized below. I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

___ Drug or Alcohol Abuse (Signature) _____ Date _____

For the purpose of: ___Healthcare ___Insurance ___Personal ___Legal ___Other_____

This authorization shall remain in effect until the following date, event or condition: _____
If no date, event or condition is specified, this authorization will expire in 6 months.

1. I understand I have the right to revoke this authorization at any time.
2. I understand that if I revoke this authorization I must do so in writing.
3. I understand a revocation will not apply to information that has already been released in response to this authorization.
4. I understand a revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
6. I need not sign this authorization to assure treatment.
7. I understand that I may inspect or receive copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
8. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by the federal privacy regulations the information described above may be redisclosed and no longer be protected by these federal regulations
9. If I have any questions about the disclosure of my health information I can contact the Avera St. Lukes Privacy Officer at (605) 622-5284.

_____ _____
Signature of Patient or Legal Guardian Date of Signature

_____
Relation (if NOT the patient)

_____ _____
Signature of Witness Date of Signature