Avera McKennan Hospital & University Health Center
800 East 21st Street
PO Box 5045
Sioux Falls, SD 57117-5045
(605) 322-8000

AUTH REL

Patient Identification	Patient Name: _____ Date of Birth: _____ Address: _____ City/State/Zip: _____ (Maiden/Previous Names/Nickname): _____ Social Security Number: _____
Provider (Who is releasing information?)	The following individual or organization is authorized to make the disclosure: Provider Name: _____ Address: _____ Phone: _____ City/State/Zip: _____
Disclose Information to: (Where is information to be sent?)	Name/Facility: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____
Information to be Disclosed	❑ Standard Chart Copy (Includes Demographic Face Sheet, Physician Dictated Reports, All Test Results) ❑ Entire Record ❑ Other _____ ❑ History and Physical ❑ Discharge Summary ❑ Lab ❑ X-ray and imaging reports ❑ EKG ❑ Operative Report ❑ Pathology Report
Service Dates	Dates of service from (date) _____ to (date) _____
Substance Abuse Documentation	Check this box ONLY if you permit substance abuse records to be released. ❑ Requestor, take note: These released records contain substance abuse documentation, and therefore prohibition on redisclosure applies. THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISION OF FEDERAL STATUTES (42 U.S.C. 290dd-2, and regulations 42 CFR, Part 2) which prohibits any further disclosure of this information without the specific written consent of the person to who it pertains, or as otherwise permitted by such regulations.
Purpose of Disclosure	❑ Continued Healthcare ❑ Completion/Payment ❑ Personal ❑ Other _____ (Purpose not required for personal requests) A copying fee may be charged on requests for purposes other than patient care.
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 one year from this date, for records generated as a result of services occurring on or prior to this date.
Revocation	I understand I have a right to revoke this authorization at any time by presenting a written revocation to the Medical Record Department. I understand the revocation will not apply to: • Information already released in response to this authorization • My insurance company when the law provides my insurer with the right to contest a claim under my policy.
Authorization	I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed, as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the Avera McKennan Privacy Officer at (605) 322-7801. _____ _____ Signature of Patient or Legal Representative Date _____ _____ If Signed by Legal Representative, Relationship to Patient Signature of Witness Date: _____ Information sent: _____