



AUTHORIZATION FORM FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

SURGERY CENTER ADDRESS: 216 ANAMARIA DR., RAPID CITY, SD 57701 (605-721-4700) FAX (721-4708)
IMAGING CENTER ADDRESS: 215 ANAMARIA DR., RAPID CITY, SD 57701 (605-721-4800) FAX (721-4826)
BUSINESSS OFFICE/HEALTH INFORMATION MANAGEMENT: 1868 LOMBARDY DR., RAPID CITY, SD 57703 (605-721-4900) FAX (721-4948)

This form, if appropriately signed, will authorize Black Hills Surgery Center to request or disclose specified protected health information.

I. I hereby authorize the disclosure of protected health information relating to:

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

II. The persons who are authorized to receive this information are:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

III. The information to be disclosed is: (specify the exact information to be disclosed, including dates of service):

**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 not, 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.

Place an "X" here _____ to disclose the complete treatment record(s) for the following date(s) of service _____, which may contain all the documents listed below as well as other notes/documents relating to my hospitalization.

Place an "X" here _____ to disclose only the specified records as indicated below:

Please Check	Document/Report/Study	Date of Service
	History and Physical Examination	
	Consultation Reports	
	Imaging Reports (CT/MRI)**	
	Imaging Films or CD (please circle one)	
	Laboratory Tests	
	Operative Report	
	Discharge Summary	
	Progress Notes	
	Other: (please specify)	

IV. I understand that the disclosed information may include information relating to:

- Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection.
- Treatment for drug or alcohol abuse.

- Mental or behavioral health or psychiatric care.

V. The information disclosed is to be sent by:

_____ Fax _____ Via Internet/Email (when applicable) _____ Mail
_____ Held for pickup by _____
(name of person authorized to pick up)

VI. Purpose(s) of Disclosure:

VII. Potential for Re-disclosure:

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

VIII. Effect of Refusing Authorization:

If you refuse to sign this authorization, we will not deny you any treatment that is covered by your general consent to the use and disclosure of protected health information for purposes of our treatment, payment or healthcare operations.

IX. I acknowledge the following statements:

- _____ Initials: I understand that I generally may revoke this authorization at any time by notification in writing to:

Black Hills Surgery Center
Attn: Privacy Official
1868 Lombardy Drive
Rapid City, SD 57703

of my intent to revoke this authorization, except that if I do notify Black Hills Surgery Center in writing of my intent to revoke this authorization, such revocation will not have any affect on any actions by Black Hills Surgery Center taken before the revocation.

- _____ Initials: Unless otherwise revoked, this authorization will expire on: _____
- _____ Initials: I understand that Black Hills Surgery Center will give me a copy of this authorization form after I sign it.

Signature of patient or patient's legally authorized representative (signers other than the patient must present legal documentation that authorizes them to act on the patient's behalf)

Date: _ / _ / _ _ _ _

Printed name of patient's representative:

Relationship to patient giving representative authority to act for patient

X. Restrictions on Releasing Protected Health Information

XI. Staff Member Completing Authorization

Signature of Staff Member Completing Authorization

Date

Comments

