Authorization for Use/Disclosure of Protected Health Information

BLACK HILLS ORTHOPEDIC & SPINE CENTER
Specializing in what moves you.

NAME: _____ DOB: _____

MAIDEN OR OTHER NAME: _____

SSN: _____

RELEASING INFORMATION TO:

Name: _____

Address: _____

_____

Phone/Fax: _____

RELEASING INFORMATION FROM:

Name: _____

Address: _____

_____

Phone/Fax: _____

INFORMATION TO BE RELEASED:

Dates: _____

☐ Progress Notes
☐ Operative Reports
☐ Imaging Reports
☐ Lab Work
☐ Other: _____

PURPOSE OF DISCLOSURE:

☐ Continuity of Care
☐ Legal
☐ Workers' Compensation
☐ Insurance
☐ Other (please specify): _____

_____

This authorization shall be in force and effect until 1 YEAR FROM DATE LISTED BELOW at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the above listed address. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure of the protected health information.

Signature of Patient or Personal Representative _____

Relationship If Other Than Patient _____

Witness _____

Date _____

A MINIMUM COPY FEE MAY BE CHARGED FOR ANY PROTECTED HEALTH INFORMATION RELEASED. PREPAYMENT IS REQUIRED.

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