Madison
REGIONAL HEALTH SYSTEM
323 S.W. 10TH STREET • MADISON, SD 57042
PHONE 605-256-6551 • FAX 605-256-6469

Authorization to Disclose Health Information

Patient Name:_____ Health Record Number:_____

Date of Birth:_____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

   _____

   Address:_____
3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
   - ☐ Medication List
   - ☐ Immunization Record
   - ☐ History and Physical
   - ☐ Discharge Information
   - ☐ Clinic Visit Note
   - ☐ Laboratory Results from (date) _____ to (date)_____
   - ☐ X-Ray Reports from (date) _____ to (date)_____
   - ☐ Consultation Reports from (doctor's name(s)) _____
   - ☐ Other _____

     _____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

   _____

   Address:_____

   For the purpose of:_____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. 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 will expire in one year.
7. I understand that 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 receive treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal privacy rules.

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If signed by Legal Representative, Relationship to Patient Signature of Witness