AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

RE: Patient's Name _____

Social Security Number _____

Birth Date _____

Address _____

_____

County of Residence _____

Admission Date_____

I hereby authorize _____ to release to Lake County medical information concerning my care and treatment during this period of hospitalization. I further authorize the county to release such medical information to providers or cooperating state or federal agencies.

I understand that the records concerning this admission may include information regarding drug and/or alcohol abuse, HIV testing, or mental health records. I acknowledge that such information is protected by federal and/or state law and I hereby release the above-named hospital from all legal responsibility or liability that may arise as a result of this action.

This authorization is given only in connection with its use by Lake County in the administration of its programs under the provisions of SDCL chapters 28-13, 28-13A, and 28-14. I understand that this information will be considered confidential and shared only with individuals, agencies, institutions, or facilities assisting with my financial needs.

A photocopy of this release shall be as valid as the original.

I understand that this authorization may be revoked by me in writing at any time before my records are disclosed, and that this authorization is valid for no more than one (1) year from the date of my signature.

Dated this _____ day of _____, _____.

_____
Patient's Signature

_____
Signature of parent, guardian, spouse, or authorized representative if patient is either a minor or incapacitated

_____
Relationship to Patient