



800 East 21st Street  
 PO Box 5045  
 Sioux Falls, SD 57117-5045  
 (605) 322-8000



AUTH REL

<b>Patient Identification</b>	Patient Name: _____ Date of Birth: _____
	Address: _____
	City/State/Zip: _____
	(Maiden/Previous Names/Nickname): _____
	Social Security Number: _____

<b>Provider</b> (Who is releasing information?)	The following individual or organization is authorized to make the disclosure:
	Provider Name: _____
	Address: _____ Phone: _____ City/State/Zip: _____

<b>Disclose Information to:</b> (Where is information to be sent?)	Name/Facility: _____
	Address: _____
	City/State/Zip: _____
	Phone: _____ Fax: _____

<b>Information to be Disclosed</b>	<input type="checkbox"/> Standard Chart Copy	<input type="checkbox"/> Discharge Summary
	<input type="checkbox"/> (Includes Demographic Face Sheet, Physician Dictated Reports, All Test Results)	<input type="checkbox"/> Lab
	<input type="checkbox"/> Entire Record	<input type="checkbox"/> X-ray and imaging reports
	<input type="checkbox"/> Other _____	<input type="checkbox"/> EKG
	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Operative Report
		<input type="checkbox"/> Pathology Report

<b>Service Dates</b>	Dates of service from (date) _____ to (date) _____
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<b>Purpose of Disclosure</b>	<input type="checkbox"/> Continued Healthcare <input type="checkbox"/> Completion/Payment <input type="checkbox"/> Personal <input type="checkbox"/> Other _____ (Purpose not required for personal requests) A copying fee may be charged on requests for purposes other than patient care.
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<b>Expiration Date</b>	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.

<b>Revocation</b>	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:
	<ul style="list-style-type: none"> <li>• Information already released in response to this authorization</li> <li>• My insurance company when the law provides my insurer with the right to contest a claim under my policy.</li> </ul>

<b>Authorization</b>	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: _____