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

AUTH REL

Patient Name: _____ Date of Birth:_____

Address: _____ Social Security #: _____

I authorize the use or disclosure of the above named individual's health information as described below.

The following individual or organization is authorized to make the disclosure:

Name: _____ Phone: _____

Address: _____
Street City State Zip

The type and amount of information to be used or disclosed is as follows:

Dates of service from (date) _____ to (date) _____

- ❑ Standard Chart Copy (Includes Demographic Face Sheet, Physician Dictated Reports, All Test Results)
- ❑ Entire Record
- ❑ Other _____ _____
- ❑ History and Physical
- ❑ Discharge Summary
- ❑ Lab
- ❑ X-ray and imaging reports
- ❑ EKG
- ❑ Operative Report
- ❑ Pathology Report

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.

This information may be disclosed to and used by the following individual or organization:

Name: _____ Phone: _____

Address: _____
Street City State Zip

for the purpose of: ❑ Continued Healthcare ❑ Completion/Payment ❑ Personal ❑ Other _____
(Purpose not required for personal requests) A copying fee may be charged on requests for purposes other than patient care.

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:

- Information already released in response to this authorization
- 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 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.

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: _____