Huron Regional Medical Center

☐ Hospital - 172 4th Street SE, Huron, SD 57350 - Fax 605-353-6590
☐ HRMC Physician's Clinic - 534 Oregon Avenue SE, Huron, SD 57350 - Fax 605-353-6590
☐ Women's Wellness Center - 142 3rd Street, Suite 2, Huron, SD 57350 - Fax 605-554-1021

Authorization for Disclosure of Health Information

1. **I hereby authorize** [name of provider/hospital]_____ to disclose information from the health records of:

   Patient's legal name_____ Date of birth _____

   covering the period(s)

   From (date) _____ to (date)_____

   From (date) _____to (date)_____

2. **Information to be disclosed:**

   ☐ laboratory/pathology test results ☐ discharge summary ☐ operative report
   ☐ history & physical examination ☐ progress notes ☐ consultation reports
   ☐ imaging film (type) _____ ☐ imaging reports ☐ photographs
   ☐ HRMC Physician's Clinic ☐ HRMC Surgical Clinic ☐ Women's Wellness Center
   ☐ billing records _____
   ☐ other (please specify) _____

   State and federal law restricts release of information regarding patient cases associated with HIV, abuse, alcohol or drug abuse, psychiatric cases, and access to STI services by minors. I authorize information relating to the following:

   ☐ yes ☐ no acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV)
   ☐ yes ☐ no behavioral health service/psychiatric care
   ☐ yes ☐ no treatment for abuse, alcohol and/or drug abuse
   ○ yes ○ no sexually transmitted infection testing and treatment (minor age 12-17)

3. **This information is to be disclosed to** (name and address) _____

   _____

   for the purpose of (optional when requesting for self) _____

4. Information to be released via ☐ Paper ☐ Compact Disc ☐ Patient Portal

5. **I understand** this authorization may be revoked in writing at any time, except to the extent that action has been taken in response to this authorization. **With exclusion of Patient Portal, unless otherwise revoked, this authorization will expire in 90 days from the date signed.**

6. **I understand** that once this information is disclosed, it may be redisclosed and no longer subject to the privacy protections afforded by federal privacy laws.

   Signed: _____
   (patient/parent of a minor) (date)

   _____
   or (personal representative-attach copy of document granting authority) (date)

Date Disclosed_____By Whom_____

Route to Health Information Management Dept.