

**AUTHORIZATION FOR USE OR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION**

Coteau des Prairies Health Care System  
205 Orchard Drive Sisseton, SD 57262

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **MR#/VISIT#:** \_\_\_\_\_

I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my health record. (Name of patient or Personal Representative)

1. I authorize the disclosure of health information by Coteau des Prairies Health Care System **to be sent to:**

To: \_\_\_\_\_ Address: \_\_\_\_\_

**OR**

2. I authorize the disclosure of health information be **OBTAINED FROM:**

To: \_\_\_\_\_ Address: \_\_\_\_\_

*To be sent to Coteau des Prairies Health Care System.*

3. The purpose or need for this disclosure is:

- |   |                                    |                                     |   |
|---|------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Further Medical Care | <input type="checkbox"/> Attorney  | <input type="checkbox"/> School     | <input type="checkbox"/> Research               |
| <input type="checkbox"/> Personal Use         | <input type="checkbox"/> Insurance | <input type="checkbox"/> Disability | <input type="checkbox"/> Other (Specify): _____ |

4. The type of information to be used or disclosed is as follows:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Discharge summary     | <input type="checkbox"/> History & Physical     | <input type="checkbox"/> Clinic notes                            |
| <input type="checkbox"/> Emergency room report | <input type="checkbox"/> Operative Report       | <input type="checkbox"/> Home health records                     |
| <input type="checkbox"/> Lab results           | <input type="checkbox"/> Radiology reports      | <input type="checkbox"/> Radiology films                         |
| <input type="checkbox"/> EKG report            | <input type="checkbox"/> Consultation           | <input type="checkbox"/> Physical/Occupational/SLP therapy notes |
| <input type="checkbox"/> Medication list       | <input type="checkbox"/> Discharge instructions |  |

OTHER: \_\_\_\_\_

Please list dates: \_\_\_\_\_

**5. If you'd like any of the following sensitive information disclosed, check the applicable boxes below:**

- |  |   |
|--|---|
| <input type="checkbox"/> Alcohol/Drug Abuse Treatment/Referral   | <input type="checkbox"/> HIV/AIDS-related Treatment                     |
| <input type="checkbox"/> Sexually Transmitted Diseases   | <input type="checkbox"/> Mental Health (Other than Psychotherapy Notes) |
| <input type="checkbox"/> Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege) |   |



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6. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. Specify new date: \_\_\_\_\_

I understand that Coteau des Prairies Health Care System will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

***I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164), and the Privacy Act of 1974 (5 USC 552a).***

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient)	DATE
SIGNATURE OF WITNESS (S)	DATE

Two witnesses REQUIRED if obtaining a verbal or phone consent      Patient ID has been verified via \_\_\_\_\_

