COTEAU DES PRAIRIES HEALTH CARE SYSTEM
205 ORCHARD DRIVE*SISSETON, SD 57262
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: **DOB:** **MR#**

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

Release information **FROM:**

☐ Coteau des Prairies Health Care System
205 Orchard Dr, Sisseton SD 57262 *Phone: 605-698-7647
*Fax: 605-698-4613

☐ Other (specify below)

Name

Address

Fax number Phone Number

Release information **TO:**

☐ Coteau des Prairies Health Care System
205 Orchard Dr, Sisseton SD 57262 *Phone: 605-698-7647
*Fax: 605-698-4613

☐ Other (specify below)

Name

Address

Fax number Phone number

The purpose of this disclosure is:

☐ Further Medical Care ☐ Legal ☐ School ☐ Research

☐ Personal Use ☐ Insurance ☐ Disability ☐ Other (Specify)_____

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

☐ Discharge summary ☐ History & Physical ☐ Clinic notes ☐ Immunization record
☐ Emergency room report ☐ Operative Report ☐ Home health records
☐ Lab results ☐ Radiology reports ☐ Radiology films
☐ EKG/Cardiology report ☐ Consultation ☐ Physical/Occupational/SLP therapy notes
☐ Medication list ☐ Discharge instructions ☐ Itemized billing/claim forms

OTHER: _____

Please list service dates: _____

If you would like any of the following sensitive information disclosed, check the applicable boxes below: ☐ Not applicable

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health (Other than Psychotherapy Notes)
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

Delivery method: (select one)

☐ Pick-up at CDP ☐ Mail (address above) ☐ Fax (number above) ☐ CD

☐ Secure email (there is risk of being intercepted /being read during transmission, only check if you still want records emailed) _____

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 If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated.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 redisclosure 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**_____

REVISED: 4/17/2020, 5/13/2020; 8/18/2023