The Huron Clinic Foundation, Ltd.
111 Fourth St SE
Huron, SD 57350

605-352-8691 Phone
605-352-8704 Fax

INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

AUTHORIZATION

I hereby authorize my physician and/or the administrative and clinical staff at:	to use and/or disclose my protected health information to:

PROTECTED HEALTH INFORMATION TO BE USED OR DISCLOSED

_____ Current record (last two years) _____ X-ray report(s) dated _____

_____ Lab report(s) dated _____ _____ Office notes dated _____

_____ Other: _____

_____

DO NOT DISCLOSE

_____ HIV/STD test results _____ Other: _____

REASON FOR USE OR DISCLOSURE

_____ Second opinion _____ Dissatisfied with service _____Moving to new location

_____ Transfer of care _____ Other (specify):_____

This authorization shall expire upon (check one):

☐ fulfillment of this request
☐ a specified date:_____
☐ 180 days from the date of this authorization.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Huron Clinic's Privacy Officer. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. I understand that under certain circumstances I may be charged fees for the copying, faxing, or mailing of my records. Fees are to be paid at time of service.

SIGNATURE FOR AUTHORIZATION

I certify that the information listed above is correct to the best of my knowledge, and that I am giving this authorization voluntarily. By signing as personal representative to the patient, I certify that I have legal authority to do so.

_____ _____
Signature Relationship to Patient

_____ _____
Print Patient's Name Date of Birth (MM/DD/YY) Date