ORTHOPEDIC INSTITUTE
810 E. 23rd Street
Sioux Falls, SD 57117-5116
Tel (605) 331-5890 or 1-888-331-5890
Fax (605) 336-3974

AUTHORIZATION
FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

Date needed by: _____
[ ] To be picked up
[ ] To be mailed
[ ] To be faxed to _____

Patient Identification

Name: _____ Date of Birth: _____

Address: _____ Phone: _____ Cell: _____

City/State/Zip: _____

Maiden/Previous Names/Nickname: _____

Provider
(Who is releasing information?)

Provider/Facility Name: _____

Address: _____ Phone: _____

City/State/Zip: _____

Disclose Information To:
(Where is information to be sent?)

Name/Facility: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

To assure confidentiality, it is the policy of Orthopedic Institute to send records via first-class mail. Orthopedic Institute will transmit records via facsimile only when requested and expressly authorized by the patient.

Information to be Disclosed

[ ] All Records
[ ] Clinic Progress Notes
[ ] X-ray Films & Reports
[ ] Lab Data
[ ] Pathology Reports
[ ] Other: _____

Purpose of Disclosure
(Please Be Specific)

[ ] Continuing Medical Care
[ ] Insurance Claim
[ ] Other (Specify): _____
[ ] Consult / Second Opinion
[ ] Legal
[ ] Out of town move
[ ] Personal

Expiration Date

This authorization will expire one year from the date of signature or on _____

Revocation

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/ provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization; or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Authorization

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party identified in the section entitled "Disclose Information To". I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits.

_____ _____
Signature of patient/representative Signature Date

_____ _____
(Relationship to patient, if signed by representative) (Witness - optional)

Please supply proof of authority to act. For minors, proof only required if other than parent.

Disposition

For office use only:

Date Sent: _____ Sent by: _____

Chart # _____

Form 105 7/09

Print Clear