SAME DAY SURGERY CENTER LLC

651 Cathedral Dr. Rapid City, SD 57701

AUTHORIZATION FOR DISCLOSURE/ RELEASE OF MEDICAL INFORMATION
(Page 1 of 2)

Request #: _____ Medical Record #: _____

Patient's Legal Name: (PRINT) _____ Date of Birth: _____

I hereby authorize the facility named **Same Day Surgery Center, LLC** to use or disclose the following medical records for the above named individual.

Information to be disclosed:

Anesthesia Records	Pathology Report	Laboratory
Physical Therapy Notes	X-Ray/CT/Nuclear Medicine	Doctor's orders
Nurse's Notes	Discharge Summary	History and Physical
Progress Notes	Consultation Reports	Operative Summary
	Discharge Instructions	Complete Medical Record

Other: _____

Please specify dates of service: _____

Please release these records to: Name: _____

Address: _____

_____

Telephone #: _____ Fax #: _____

For the purpose of: Personal Use Insurance Continuing Care Legal Other: _____

Your initial below allows the designated facility to disclose information protected under Federal law relative to **alcohol and drug** related diagnosis and treatment, **OR allows us to specifically inform you that the medical record contains information specific to HIV, AIDS, Sickle Cell Anemia, or Psychiatric Care.** "Drug and alcohol information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information **is not sufficient for this purpose**."

I understand this will not include information related to: **(initial if applicable or line through if not applicable)**

_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection.
_____ Psychiatric Care
_____ Treatment for alcohol and/or drug abuse
_____ Sickle Cell Anemia

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I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, or other benefits. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carried with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Release of Information Technicians.

I hereby release the above-designated facility from all legal responsibility or liability, which may arise from any act I have authorized.

Patient/Legal Representative Signature: _____ Date: _____

Specify Relationship if not Patient: _____

Authorization Witnessed by: _____ Date: _____