Huron Regional Medical
☐ Hospital - 172 4th St. SE, Huron, SD 57350 - Fax 605-353-6590
☐ HRMC Physicians Clinic - 534 Oregon Avenue SE, Huron, SD 57350
Fax Numbers: ☐ Internal Med 605-353-7380 ☐ Surgical Clinic 605-353-7661 ☐ Pediatric Clinic 605-353-7381

Authorization for Disclosure of Health Information

1. **I hereby authorize** [name of provider/hospital]_____
to disclose information from the health records of:

   Patient's legal name_____ Date of birth _____

   covering the period(s)

   From (date) _____ to (date)_____

   From (date) _____to (date)_____

2. **Information to be disclosed:**

   ☐ laboratory/pathology test results ☐ discharge summary ☐ operative report
   ☐ history & physical examination ☐ progress notes ☐ consultation reports
   ☐ imaging film (type) _____ ☐ imaging reports ☐ photographs
   ☐ HRMC Physicians Clinic
   ☐ billing records _____
   ☐ other (please specify) _____

   State and federal law restricts release of information regarding patient cases associated with HIV, abuse, alcohol or drug abuse and, psychiatric cases. My initials authorize disclosure of information relating to the following:

   _____ acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV)
   _____ behavioral health service/psychiatric care
   _____ treatment for abuse, alcohol and/or drug abuse
   _____ sexually transmitted infection testing and treatment (only for minors age 12-17)

3. **This information is to be disclosed to** (name and address)_____
_____

   for the purpose of (optional when requesting for self) _____

4. Information to be released via ☐ Paper ☐ Compact Disc ☐ Patient Portal

5. **I understand** this authorization may be revoked in writing at any time, except to the extent that action has been taken in response to this authorization. **With exclusion of Patient Portal, unless otherwise revoked, this authorization will expire in 90 days from the date signed.**

6. **I understand** that once this information is disclosed, it may be re disclosed and no longer subject to the privacy protections afforded by federal privacy laws.

   Signed: _____
   (patient/parent of a minor) (date)

   _____
   or (personal representative-attach copy of document granting authority)(date)

Date Disclosed_____By Whom_____

Route to Health Information Management Dept.