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 _____

Today's Date:

Patient Identification	Name:		Date of Birth:		
	Address:		Phone:	Cell:	
	City/State/Zip:	,			
	Maiden/Previous Names/Nickname:				
Provider (Who is releasing information?)	Provider/Faculty 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	☐ Lab Data	☐ Other: _____		
	☐ Clinic Progress Notes	☐ Pathology Reports			
	☐ X-ray Films & Reports				
Purpose of Disclosure (Please Be Specific)	☐ Continuing Medical Care	☐ Consult / Second Opinion	☐ Out of town move		
	☐ Insurance Claim	☐ Legal	☐ Personal		
	☐ Other (Specify):				
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:		
Form 105 04/13	Chart #:				