Sioux Falls
CENTER FOR PLASTIC & RECONSTRUCTIVE SURGERY
Compassion · Experience · Trust

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AUTHORIZATION TO RELEASE PROTECTED HEALTHCARE INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and our Practice may want to use PHI for reasons other than treatment, payment, and health care operations. This Form summarizes the antipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

- ☐ All Records (including X-Ray)
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ X-ray Reports
- ☐ X-rays
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Doctor/Clinic Notes
- ☐ Other: _____

The above mentioned protected health information may be subjected to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose protected health information (PHI) about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization.

Patient Signature: _____ Date Signed: _____