BROOKINGS HEALTH SYSTEM
300 22ND AVENUE
BROOKINGS, SD 57006
Phone: 605-696-9000 Fax: 605-696-8850

AUTHORIZATION TO RELEASE INFORMATION

I authorize Brookings Health System to use or disclose my health information as described below. I hereby voluntarily and knowingly execute this release with the express intention to release Brookings Health System from any claim arising from this agreement.

_____ DOB: _____
(Patient name) Please print (Patient)

Information needed by (date) _____ Home Phone Number:_____

Information requested from the following date(s) of service: _____
Information to be released includes:

- □ Discharge Summary
- □ History and Physical
- □ Consultation
- □ Laboratory Results
- □ X-ray Reports/ □ Films
- □ Operative Note
- □ Pathology Report
- □ Emergency Room Report/Note(s)
- □ Entire record for date of service
- □ Other (please describe) _____

I authorize Brookings Health System to disclose health information related to: (please check and initial all that apply): I understand that records related to the following will not be released without my initials showing authorization to release.

- □ Sexually transmitted disease _____
- □ Alcohol use/abuse _____
- □ Suicide attempt _____
- □ Drug abuse _____
- □ AIDS/HIV _____
- □ Forensic evidence _____
- □ Psychiatric admission _____

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to the Medical Health Information Department at Brookings Health System. 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.

If I fail to specify an expiration date, event, or condition, this authorization will expire six months from the date of signing. I also understand that if I refuse to sign this form, copies of my record may not be released to the requesting party.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

_____ _____
Company or person authorized to receive information Address of company or person to receive information

_____ _____
Patient's Signature or Signature of Patient's Representative Date
(Patient Representative's authority _____)

This information is being disclosed for the following purpose(s): _____

_____ Information Released □ Yes Date _____
Hospital Personnel Signature - Witness/Date

Information Released by _____

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