# AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

**Today's Date:** _____

**Date Needed by:** _____

☐ Paper **OR** ☐ CD

☐ Fax ☐ Email ☐ Mail ☐ Pick Up at: **(Circle one)**
☐ Baken Park Black Hills Urgent Care
☐ Haines Ave. Black Hills Urgent Care

## PATIENT INFORMATION:

| | | |
|---|---|---|
| **Name:** | **Date of Birth:** | |
| **Address:** | **Phone:** | **Cell:** |
| **City/State/Zip:** | **Email Address:** | |
| **Maiden/Previous Names/Nickname:** | | |

## OBTAIN INFORMATION FROM:

| | |
|---|---|
| **Provider/Facility Name:** | |
| **Address:** | **Phone:** |
| **City/State/Zip:** | |

## DISCLOSE INFORMATION TO:

| | |
|---|---|
| **Name/Facility:** | |
| **Address:** | **Phone:** |
| **City/State/Zip:** | **Fax:** |

## INFORMATION TO BE DISCLOSED

**Dates of Treatment:** _____ through _____ ; **OR** ☐ All Dates

☐ Entire Record ☐ Provider Notes
☐ Nursing Medication Record ☐ Pathology/Laboratory Report
☐ X-ray report ☐ Pre-work Screen
☐ History & Physical Exam ☐ Drug/Alcohol Screen
☐ PFT/FIT Test ☐ Billing Records

## PURPOSE OF DISCLOSURE

☐ Continuing Medical Care ☐ Consult/Second Opinion
☐ Legal ☐ Personal
☐ Out of town move ☐ Employment
☐ School ☐ Other (Specify)_____
☐ Military
☐ Insurance Claim

**EXPIRATION DATE:** ☐ This authorization will expire one year from the date of signature **OR** ☐ On this date: _____.

## REVOCATION

I understand that I may revoke this authorization at any time by sending a written notice to the applicable Black Hills Urgent Care address listed below. 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 behavioral and mental health services, psychiatric care, treatment for drug and alcohol abuse, sexually transmitted diseases, and HIV and/or AIDS 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. I understand the BHUC has the right to charge a reasonable cost based fee for reproduction and mailing of my medical records, unless it's for continuing medical care.

| | |
|---|---|
| | |
| **Signature of patient/parent/personal representative** | **Date** |
| | |
| **(Relationship to patient, if signed by parent/personal representative)** | *Please supply proof of authority to act.* |

**Date released:**_____ **Released by:**_____ **Comments:**_____


**Baken Park Urgent Care**
741 Mountain View Dr.
Suite 1
Rapid City, SD 57702
(P) 605-791-7777
(F) 605-791-7766

**Haines Urgent Care & Occupational Medicine**
I-90 Exit 58 – 1730 Haines Ave
Rapid City, SD 57701
(P) 605-791-7788 * (F) 605-791-7755
**Occupational Medicine**
(P) 605-718-2778 * (F) 605-718-2780


BLACK HILLS URGENTCARE
Proudly Owned by Physicians