BLACK HILLS REGIONAL EYE INSTITUTE, LLP
BLACK HILLS REGIONAL EYE SURGERY CENTER, LLC
BLACK HILLS REGIONAL REFRACTIVE EYE SURGERY CENTER, LLC
2800 THIRD STREET
RAPID CITY SD 57701
605-341-2000 OR 1-800-658-3500
FAX: 605-341-0278

AUTHORIZATION FOR RELEASE (DISCLOSURE) OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________

Social Security Number: ______________________________

Date of Birth: ______________ **Previous Name (if any):** ______________

Address: ______________________________

City: ______________ **State:** ______________ **Zip:** ________

THIS WILL AUTHORIZE RELEASE OF MEDICAL INFORMATION FROM:

Physician: ______________________________

Address: ______________________________

City: ______________ **State:** ______________ **Zip:** ________

SEND INFORMATION TO:

Name: ______________________________

Address: ______________________________

City: ______________ **State:** ______________ **Zip:** ________

Information to Be Used or Disclosed
The information covered by this authorization includes:

- ☐ History and exam
- ☐ Other ______________________________
- ☐ Progress Notes
- ☐ Diagnostic Tests

Purposes of Disclosure
Information listed above will be disclosed for the following purposes:

- ☐ Changing physicians
- ☐ School
- ☐ Surgery
- ☐ Consultation/second opinion
- ☐ Insurance
- ☐ Continuing care
- ☐ Workers Compensation
- ☐ Legal
- ☐ Other: ______________________________

1. I understand that this authorization will expire on ________________(if applicable) unless revoked or terminated earlier by the patient of the patient's representative.

2. I understand that I may revoke this authorization at any time by notifying the Black Hills Regional Eye Institute in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.

3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

Rights of the Individual

- You may inspect or copy information used or disclosed under this authorization.
- You may refuse to sign this authorization.

Refusing Authorization

If you refuse to sign this authorization, the Black Hills Regional Eye Institute will not deny you any treatment except research-related treatment or treatment that you have requested for the purpose of disclosure to others, including:

____

Treatment conditioned on authorization

Signatures

____

Signature of Patient Date

____

Print Name of Patient Representative (If applicaable)

____

Relationship of Patient Representative to Patient (parent, guardian, etc.)

____

Signature of Patient Representative Date