BLACK HILLS REGIONAL EYE INSTITUTE

Black Hills Regional Eye Institute, LLP
Black Hills Regional Eye Institute Real Estate Leasing Co., LLC
Black Hills Regional Eye Surgery Center, LLC
Black Hills Regional Eye Institute Refractive Surgery Center, LLC
The Eye Specialists Equipment Group, LLC
2800 Third Street Rapid City, SD 57701-7394 . 605-341-2000

AUTHORIZATION FOR RELEASE (DISCLOSURE) OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Previous Name (if any): _____ Social Security Number: _____

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 ___ Progress notes ___ Diagnostic tests Other: _____

Purpose of Disclosure. Information listed above will be disclosed for the following purposes (circle):

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

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

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.

_____ _____
Signature of Patient Date

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

_____ _____
Signature of Patient Representative Date