Authorization - Release of Medical Records Information

Patient Identification	Patient Name: _____ Date of Birth: _____ Address: _____ City/State/Zip: _____ SSN (last 4 digits): _____ Phone: _____
Provider (Who is Releasing the Information?)	The following individual or organization is authorized to make the disclosure: Prairie Rehabilitation ☐1220 E Holly Blvd, Brandon SD 57005 (P)605-582-3103 (F) 605-582-3885 ☐100 W. Hwy 38, Suite H Hartford, SD 57033 (P)605-528-1900 (F)605-528-1901 ☐301 Willow St, Ste 1, Harrisburg, SD 57032 (P)605-767-3008 (F)605-767-3009 ☐1720 S Cliff Ave Sioux Falls, SD 57105 (P)605-334-5630 (F)605-332-5327 ☐5235 W 26th St Sioux Falls, SD 57106 (P)605-271-6920 (F)605-271-0460 ☐5150 E 57th St Sioux Falls SD 57108 (P)605-271-3378 (F)605-271-6059 ☐7400 S Louise Ave. Sioux Falls, SD 57108 (P) 605-271-0808 (F)605-271-0845 ☐725 Kevin Dr. Tea, SD 57064 (P)605-368-9897 (F)605-213-0175 ☐400 7th St. Fulda, MN 56134 (P)507-425-3753 (F) 507-425-3609 ☐816 3rd St. Jackson, MN 56143 (P)507-847-4333 (F)507-847-4974 ☐403 Colonial Ave, Lakefield, MN (P)507-662-6646 (F)507-662-5569 ☐1215 Ryan's Rd -Worthington, MN 56187 (P)507-343-0068 (F)507-343-0067 ☐315 Oxford St., Worthington, MN (P)507-372-2232 (F)507-372-73269
Disclose Information To (Where is Information to be Sent?)	Name/Facility: _____ Address: _____ City/State/Zip: _____ Phone: _____ Fax: _____
Information to be Disclosed	☐Standard Chart Copy (Includes Most Recent PT/OT/ST Initial Evaluation, Progress Note(s), and All Daily Notes) ☐X-Ray and Imaging Records ☐Entire Record (Charges May Apply) ☐Other _____
Service Dates	Dates of Service from (date) _____ to (date) _____
Form and Format (Where possible/applicable)	☐Paper (pickup or mail) ☐Fax ☐Flash Drive ☐E-Mail (please provide address below) Email Address: _____ All medical records in electronic format will be unencrypted unless specifically requested otherwise by the patient. Sending medical records unencrypted has risks including the individual's PHI could be read or otherwise accessed by a third party. File sizes may limit the ability to send by e-mail. **If you want your records sent electronically, please initial here indicating you acknowledge and understand the risks associated with sending information unencrypted _____**
Purpose of Disclosure	☐Continued Healthcare ☐Completion/Payment ☐Personal ☐Worker's Compensation ☐Disability ☐Other_____
Expiration Date	Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____ If I fail to specify an expiration date, event, or condition, this authorization shall be in effect for one year from this date, for records generated as a result of services on or prior to this date.
Revocation	I understand I have a right to revoke this authorization at any time by presenting a written revocation to the organization. I understand this revocation will not apply to any information already released in response to this authorization or my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Authorization	I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand there may be a fee for a copy of records requested and I understand that all fees will be in compliance with applicable federal and state laws. I agree to pay this fee when applicable. If I have questions about disclosure of my health information, I can contact the Prairie Rehabilitation Corporate Compliance Officer at 605-334-5630. _____ _____ **Signature of Patient or Legal Representative** **Date** _____ _____ **If Signed by Legal Representative, Relationship to Patient** **Signature of Witness** **Date: _____ Information Sent: _____**

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Revocation	I understand I have a right to revoke this authorization at any time by presenting a written revocation to the organization. I understand this revocation will not apply to any information already released in response to this authorization or my insurance company when the law provides my insurer with the right to contest a claim under my policy.
Authorization	I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or obtain copies of the information to be used or disclosed as provided in 45 CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I understand there may be a fee for a copy of records requested and I understand that all fees will be in compliance with applicable federal and state laws. I agree to pay this fee when applicable. If I have questions about disclosure of my health information, I can contact the Prairie Rehabilitation Corporate Compliance Officer at 605-334-5630. _____ _____ **Signature of Patient or Legal Representative** **Date** _____ _____ **If Signed by Legal Representative, Relationship to Patient** **Signature of Witness** **Date:** _____ **Information Sent:** _____

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