New Life Clinic

118 Third Street Southeast • Huron, South Dakota 57350
Phone: 605.352.2117 • Fax: 605.554.2200

Authorization for Disclosure of Health Information

1. **I hereby authorize** (name of provider/hospital) _____
to disclose information from the health records of:

Patient's Legal Name _____ Date of Birth _____

Covering the period(s)

From (Date) _____ To (Date) _____

From (Date) _____ To (Date) _____

2. **Information to be disclosed:**

❑ Laboratory/Pathology Test Results
❑ History & Physical Examination
❑ Imaging Film (Type)
❑ HRMC Physician's Clinic
❑ Discharge Summary
❑ Progress Notes
❑ Imaging Reports
❑ HRMC Surgical Clinic
❑ Operative Report
❑ Consultation Reports
❑ Photographs
❑ Women's Wellness Center
❑ Billing Records _____
❑ Other (Please specify) _____

State and federal law restricts release of information regarding patient cases associated with HIV, abuse, alcohol or drug abuse, psychiatric cases, and access to STI services by minors. I authorize information relating to the following:

❑ Yes ❑ No Acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV)
❑ Yes ❑ No Behavioral health service/psychiatric care
❑ Yes ❑ No Treatment for abuse, alcohol and/or drug abuse
❑ Yes ❑ No Sexually transmitted infection testing and treatment (minor age 12-17)

3. **This information is to be disclosed to** (name and address) _____

_____

for the purpose of (optional when requesting for self) _____

4. **I understand** this authorization may be revoked in writing at any time, except to the extent that action has been taken in response to this authorization. **With exclusion of Patient Portal, unless otherwise revoked, this authorization will expire in 90 days from the date signed.**

5. **I understand** that once this information is disclosed, it may be redisclosed and no longer subject to the privacy protections afforded by federal privacy laws.

Signed: _____
(Patient/Parent of a minor) (Date)

_____
OR (Person Representative-attach copy of document granting authority) (Date)