The Endoscopy Center Inc.

2820 Mt. Rushmore Rd, Rapid City, SD 57701
Ph: (605) 721-8121; Fax: (605) 721-8425

# *AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION*

| | |
|---|---|
| Records Released by:<br>Staff Initials: Date: | This Authorization was revoked on:<br>Date: Staff Initials: |

Patient Name: _____ Date of Birth: _____

***I authorize The Endoscopy Center, Inc. to use or disclose the following protected health information:***

Covering the dates of service: From (Month/Year) _____ to (Month/Year) _____

| | |
|---|---|
| ____ The entire medical record (all information) | ____ Procedure Report |
| ____ Diagnostic Reports (lab, x-ray, etc.) | ____ History and Physical |
| ____ Anesthesia Record | ____ Physician's Orders |
| ____ Billing Office Record | ____ Nursing Documentation |

____ Other: (Describe as specifically as possible)

_____

_____

I understand the information to be released may include diagnoses and/or treatment for alcohol and/or drug abuse, HIV test results, AIDS/AIDS Related Complex (ARC) diagnoses and/or treatment, diagnoses and/or treatment relating to other communicable disease.

The protected health information may be disclosed to the following individual(s) or organization(s):

_____

This protected health information is being used or disclosed for the following purposes:

| | |
|---|---|
| ____ Ongoing Medical Care | ____ Initiated at the request of the patient |
| ____ Attorney | ____ Other, specify: _____ |

This authorization shall be in force and effect until:

____ Date: _____

____ The happening of the following event: _____

***Authorization Statements/Signatures:***

- I understand, as set forth in The Endoscopy Center's Privacy Notice, I have the right to revoke this authorization, in writing, at any time by sending written notification to:

The Endoscopy Center, Inc.
2820 Mt. Rushmore Rd.
Rapid City, SD 57701
Attn: Privacy Officer

- I understand a revocation will not apply to information The Endoscopy Center has released in response to this authorization.
- I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I certify this request has been made voluntarily and the information given above is accurate to the best of my knowledge.
- I understand The Endoscopy Center will not condition the provision of treatment or payment on the provision of this authorization.
- **For Marketing Disclosures Only: (check if applicable)** ____ I understand The Endoscopy Center will receive compensation related to the use or disclosure of the requested information.
- A copy or fax of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing.

***I understand I have the right to:***

- Inspect or copy my protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

**The Endoscopy Center, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.**

**Español (Spanish):** The Endoscopy Center, Inc. cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

**Deutsch (German):** The Endoscopy Center, Inc. erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Effective
10/19/2016

**For Office Use Only:** Identity of the patient or personal representative verified via:

____ Photo ID ____ Matching Signature ____ Other, specify _____

Verified by: _____ Date: _____