Coteau des Prairies Hospital and Clinic
205 Orchard Drive
Sisseton, SD 57262
(Hosp) 605-698-7647 (Clin) 605-698-7681

Browns Valley Clinic
106 4th Street Box 1
Browns Valley, MN 56219
320-695-2105

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Pt. name:_____ BD:_____ MR/ADM #_____/_____

1. ☐ I authorize the use or disclosure of the above named individual's Health information ***from Coteau des Prairies Hospital & Clinic and/or Browns Valley Clinic*** to be sent to the following:

To:_____Address:_____

2. ☐ I authorize the use or disclosure of the above named individual's Health information to be ***obtained from***:

From:_____Address:_____
To be sent to Coteau des Prairies Hospital & Clinic and/or Browns Valley Clinic.

3. **The type of information to be used or disclosed is as follows**:

☐ Discharge summary	☐ History & Physical	☐ Progress Notes
☐ Dr. Orders	☐ Emergency room report	☐ Operative Report
☐ Lab results	☐ X-ray reports	☐ X-ray films
☐ EKG report	☐ Consultation	☐ Nurse's progress notes
☐ Medication list	☐ Discharge instructions	☐ Physical therapy notes
☐ Home health records	☐ CDP clinic notes	☐ Browns Valley clinic notes

OTHER: _____

Please list dates:_____

4. **This information for which I am authorizing disclosure will be used for the following purpose**:

☐ My personal records ☐ Sharing with other health care providers as needed
☐ Legal purposes ☐ Insurance purposes
☐ Other (please describe):_____

5. I understand the following: The information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. 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 may inspect or copy the information to be used or disclosed. 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 have a right to revoke this authorization at any time. If I revoke this authorization I must do so in writing and present my written revocation to the health information department. The revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

*****This authorization will expire (insert date or event):_____ (If I fail to specify an expiration date or event, this authorization will expire in one year.)**

_____/_____/_____/_____
signature date time relationship

_____ _____
witness 2nd witness for phone consent

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