



### HIPAA Privacy and Release of Information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

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**HIPAA Privacy and Release of Information Authorization:** I hereby authorize PCHC and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services. I have been advised of this practice’s Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority. I acknowledge I have received the Notice of Privacy Practices and understand I may request a copy of Promise’s Notice of Privacy Practices at any time.

**Health Information Exchange:** I understand that Promise participates in the electronic exchange of health information with other health care providers through South Dakota Health Link. Unless I choose to opt out, my electronic health information will be accessible through South Dakota Health Link to properly authorized users for purposes of treatment, payment, and health care operations only. To opt out or find out more, I can find information at sdhealthlink.org or ask for staff assistance.

**Financial Responsibility:** My signature below indicates that I accept financial responsibility for this account and for payment of services provided to me and to my spouse and/or my dependents.

I certify that the information I have provided is true and correct to my knowledge.

**If signed by legal representative:**

By signing this form, I represent that I am the legal representative of patient/s identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the patient’s behalf with respect to this authorization form.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_