State of South Dakota

OFFICE OF ATTORNEY GENERAL
Marty J. Jackley

Authorization Form for Disclosure of Protected Health Information (HIPAA Release)

_____ _____
Patient Name (please print) Date of Birth

_____ _____ _____ _____
Patient Address Town State Zip Code

1. I hereby authorize the State of South Dakota, through its authorized representative, the Office of Attorney General, to obtain any information from my medical records. Any hospital, clinic, institution, entity, or individual having such information, is hereby authorized to provide such information or a copy thereof, to the Office of Attorney General.

2. I understand that by signing this authorization, I am authorizing the release of my medical records. Such records and information may be released upon presentation of a copy of this authorization. I save and hold harmless those who comply with this release, and agree that the entities presented with the authorization will not be held liable by me for releasing these records or revealing this information.

3. I authorize the Attorney General to use the information from my records in the due and lawful execution of duties pursuant to law.

4. I give this written permission voluntarily. I understand that I have a right to revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

5. I understand and agree that a photocopy of this signed authorization shall have the same force and effect of the original. This authorization is valid for a one year period from the date on which it is signed.

6. I understand that once the above information is disclosed, it may be used by the recipient and the information may not be protected by federal privacy laws or regulations.

7. If the data subject is a minor or deceased, I attest that I am authorized by law to sign on the minor or the decedent's behalf.

_____ _____
Name of subject/minor/decedent Guardian or representative's relationship to subject

_____
Address

_____ _____
Signature of subject/guardian, representative Date