Authorization for the Use and Disclosure of Health Information

Mail or Fax to: DAKOTACARE
2600 West 49th Street
P.O. Box 7406
Sioux Falls, SD 57117-7406

(605) 334-4000
(800) 325-5598
Fax: (605) 334-8717

DAKOTACARE Department for routing.

PLEASE KEEP A COPY FOR YOUR RECORDS.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the "HITECH Act"), DAKOTACARE may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and/or disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning to our office.

I, _____ ***(print name)*** hereby authorize DAKOTACARE to use and/or disclose the following health information that pertains to me:

(Describe here the information you are authorizing us to use or disclose)

For the following purpose(s): **(either check box or fill in purpose)**

❑ At my request; or

(Describe here the purpose for the use and disclosure)

I authorize the following persons to receive these disclosures of my health information:

(Describe here the organization(s) or person(s) to whom you are authorizing DAKOTACARE to make disclosures)

I understand once information is disclosed to another party pursuant to this authorization it may be re-disclosed to additional parties and DAKOTACARE cannot guarantee its protection.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to (address or name of office). I further understand than any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

This authorization is valid until _____ ***(insert a date or describe an expiration event).*** If no other date is identified the authorization will be valid for no more than one year from the date signed.

I understand that I am under no obligation to sign this authorization. However, DAKOTACARE may not be able to release information or provide certain benefits without this authorization.

_____ _____
Signature Date

_____ _____ _____
Print Name Member # Phone #

REVOCATION SECTION
I hereby revoke this authorization.

_____ _____
Signature Date

FOR DAKOTACARE USE ONLY

VALID ❑ **INVALID** ❑ **REVOKED** ❑ **INITIALS:** _____ **DATE:** _____