South Dakota Bureau of Human Resources

Benefits Program

Authorization for the Use and Disclosure of Protected Health Information

Mail or Fax to: Bureau of Human Resources
Benefits Program
500 East Capitol
Pierre, SD 57501-5070

(605) 773.3148
Fax: (605) 773.6840

PLEASE KEEP A COPY FOR YOUR RECORDS.

Employee / Spouse / Dependent the employee / spouse / dependent whose information may be released is:

Name:		Date of Birth:
Address:	City:	ST/Zip:
Employee ID Number:		Last four digits of SSN:

Protected Health Information The information for the disclosure is:

☐ Medical Records (Describe & include time frame):

☐ Other (Describe):

Disclosure The following person(s) or organization(s) are to **provide** the protected health information:

Name: Phone:

Address: City: ST/Zip:

Name: Phone:

Address: City: ST/Zip:

Recipient The following person(s) or organization(s) are to **receive** the protected health information:

Name: Phone:

Address: City: ST/Zip:

Purpose of the Release or Disclosure of Information The reason I am authorizing release is:

☐ My request

☐ Other (describe):

Expiration This Authorization expires (periods longer than one year must be designated):

Date: **OR** Event:

Explanation of Rights

I understand that:

- I can revoke this Authorization at any time by giving my written revocation to the BHR Benefits Program. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.
- The BHR Workers' Compensation Program may NOT condition treatment or workers' compensation benefits on whether I sign this Authorization. If I refuse to sign this Authorization or revoke it at a later date, such refusal or revocation may affect any rights I may otherwise have to workers' compensation benefits pursuant to state law. See 45 CFR 164.512(l).
- I am authorizing disclosure of information protected under federal law to be used for the purpose of administering, investigating and defending against my claim for workers' compensation benefits. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.

I ACKNOWLEDGE RECEIPT OF A COPY OF THIS AUTHORIZATION.

Signature of Employee / Insured or Personal Representative Date

Representative's Relationship to Employee / Insured (if applicable) Representative's Printed Name

See BHR Notice of Privacy Practices at http://benefits.sd.gov/Files/2013/Forms/BHRprivacynotice.pdf