Community Health Center
OF THE BLACK HILLS

350 Pine Street
Rapid City SD 57701
Phone: 605-721-8939
Fax: 605-721-8998

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

All highlighted sections must be filled out completely or release will not be processed.

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME(S) USED

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____ DATE OF BIRTH: ___/___/___ SS#: ___-___-___

I hereby authorize the release of information from my medical records as indicated below:

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:**
PROVIDER/FACILITY NAME:	**PROVIDER/FACILITY NAME:**
ADDRESS:	**ADDRESS:**
CITY /STATE/ZIP:	**CITY /STATE/ZIP:**
PHONE/FAX:	**PHONE/FAX:**

INFORMATION TO BE RELEASED:

☐ PROGRESS NOTES ☐ LAB REPORTS ☐ FAMILY PLANNING ☐ HIV RELATED INFORMATION ☐ IMMUNIZATION RECORD ☐ OTHER
☐ HISTORY & PHYSICAL ☐ XRAY REPORTS ☐ MENTAL HEALTH ☐ SUBSTANCE ABUSE ☐ BILLING STATEMENT ☐ ENTIRE RECORD

☐ **I do not wish to release records containing information regarding the diagnosis or treatment of HIV (aids virus), other sexually transmitted diseases, drug or alcohol abuse, mental illness or psychiatric treatment, or Family Planning information.**

Signature: _____

PURPOSE OF DISCLOSURE:

☐ CHANGING PHYSICIANS ☐ CONTINUING CARE ☐ IDENTIFICATION CARD ☐ LEGAL ☐ SCHOOL ☐ OTHER: _____
☐ CONSULTATION ☐ DISABILITY DETERMINATION ☐ INSURANCE ☐ PERSONAL ☐ WORK COMP. _____

REQUESTED DATES OF INFORMATION: _____ TO _____

****RECORDS FOR THE LAST 2 YEARS WILL BE RELEASED IF DATES NOT SPECIFIED****

- I understand that authorizing the disclosure of this information is voluntary and upon request, I may limit the amount of time that this consent for release of information is valid. I understand that by authorizing this release of information, my health care and payment for health care will not be affected if I do not sign this form. I understand that I will receive a copy of this form after I sign it.
- I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above, and understand that the revocation will not apply to information that has already been released.
- I understand that any disclosure of information carries with it the potential of unauthorized re-disclosure by recipient and no longer protected by Federal privacy regulations.
- I understand that in compliance with South Dakota statute, I will pay a fee to cover reproduction and mailing. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment or released to patient.
- **I understand this request for information may take up to 30 days to be fulfilled.**

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name Relationship to patient if signed by Legal Representative.

This authorization will expire a year from signed date.

☐ Faxed ☐ Mailed ☐ Pick Up **Medical:** ☐ Paper ☐ Cd **Only For Records After June 2012 And Can Only Be Picked Up At Facility*
☐ E-mail _____ *only for records June 2012 to current.
Dental: ☐ Paper ☐ Email _____ Dentrix Records only.

FOR OFFICE USE ONLY
Identification Presented at pick up: _____
Completed By: _____
Date Request Filled: _____