350 Pine Street
Rapid City SD 57701
Phone: 605-721-8939
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# RELEASE OF MEDICAL INFORMATION AUTHORIZATION

PATIENT NAME: ____________________ MAIDEN OR OTHER NAME(S) USED: ____________

ADDRESS: ____________ CITY: ____________ STATE: ______ ZIP: ________

CONTACT PHONE: ____________ DATE OF BIRTH: ____________ SS#: ________

| 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:

**MEDICAL RECORDS**
- ☐Progress Notes
- ☐Lab Reports
- ☐X-ray Reports
- ☐X-ray Images – CD only
- ☐Family Planning
- ☐HIV Records
- ☐Immunization Record
- ☐Certified Medical Record
- ☐Entire Medical Record
- ☐Other: ____________

**BEHAVIORAL HEALTH RECORDS**
- ☐Assessment
- ☐Diagnosis
- ☐Psychiatric Evaluation
- ☐Treatment Plan or Summary
- ☐Medication Management Info
- ☐Discharge/Transfer Summary
- ☐Psychotherapy Notes
- ☐Entire Behavioral Health Record

**DENTAL RECORDS**
- ☐Progress Notes
- ☐X-ray Images – Email only
- ☐Treatment Plan
- ☐Certified Dental Record
- ☐Entire Dental Record

**I understand that my health record may include information regarding the diagnosis and/or treatement of the following: AIDS, HIV, sexually transmitted diseases, behavioral or mental health services, alcohol or drug abuse.**

I Do **NOT** wish to release the above information: ____________________

**FOR THE PURPOSE OF**: ☐Personal ☐Insurance ☐Continuing Care ☐Legal

**DATES OF SERVICE:**____________________(If no dates specified only 2 years of records will be released)

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.

**I understand this request for information may take up to 30 days to be fulfilled.**
**This authorization will expire a year from signed date**

____________________ ________
Signature of Patient or Legal Representative Date

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

**Records Delivery Options**
*** denotes only option for Certified Medical Record**
- ☐Faxed
- ☐*Mailed
- ☐*Pick Up
- ☐Email: ____________

**Only option available for Medical X-ray images:**
- ☐CD – only available for pick up at clinic

**For Office Use Only:**
Received By: ____________
Behavioral Health approval: ____________
Release Completed by: ____________
Date Completed: ____________
ID Presented at pick up: ____________
ROI Version updated: September 2021