



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:

PROVIDER/FACILITY NAME:
ADDRESS:
CITY /STATE/ZIP:
PHONE/FAX:

RELEASE INFORMATION TO:

PROVIDER/FACILITY NAME:
ADDRESS:
CITY /STATE/ZIP:
PHONE/FAX:

INFORMATION TO BE RELEASED:

MEDICAL RECORDS
 Progress Notes
 Lab Reports
 X-ray Reports
 X-ray Images
 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
 Treatment Plan
 Certified Dental Record
 Entire Dental Record

I understand that my health record may include information regarding the diagnosis and/or treatment 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.

- Faxed
- Mailed
- Pick Up
- Options only available for records after June 2012:
- Email: _____
- CD: only available for pick up at our clinic

For Office Use Only:
Received By: _____
Behavioral Health approval: _____
Release Completed by: _____
Date Completed: _____
ID Presented at pick up: _____