RAPID CITY MEDICAL CENTER LLP

2820 Mount Rushmore Road ~ Rapid City, SD 57701 ~ Tel: 605-342-3280 ~ Fax: 605-721-8435

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Request Records FROM:

Name_____

Facility_____

Address_____
Street or PO Box

_____
City State Zip

Phone No._____

Fax No._____

Release Records TO:

Name_____

Facility_____

Address_____
Street or PO Box

_____
City State Zip

Phone No._____

Fax No._____

Medical Records of (Patient Information):

Patient Name_____
Last First MI

Date of Birth_____ Daytime Telephone Number (_____) _____ - _____

Address_____
Street or PO Box City State Zip

Covering the date(s) of service:_____ _____
FROM Month/Year TO Month/Year

Purpose: ☐ At the Request of the Patient ☐ Continuing Care ☐ Attorney ☐ Other (specify)_____

Information to be disclosed:

☐ Complete Health Record(s) ☐ Consultation Reports ☐ Laboratory Tests ☐ Progress Notes

☐ History & Physical ☐ X-Ray Reports ☐ Discharge Summary ☐ Other

☐ Photographs, videotapes, digital or other images

I understand if my health record includes information relating to behavioral or mental health services, treatment for alcohol and/or drug abuse, sexually transmitted disease, Hepatitis B or C testing, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), it will be included in this release of records.

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by submitting my request in writing, except to the extent that action has already been taken to comply with it. I understand that I do not have to sign this authorization. I understand that my treatment or payment for services will not be denied if I do not sign this form. Without my express revocation, this authorization will expire in **180 days** from date of signature.

COPY OF AUTHORIZATION: A copy or fax of this authorization may be utilized with the same effectiveness as the original unless otherwise noted in writing. A copy of this signed authorization will be provided to the patient.

RE-DISCLOSURE: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by federal privacy laws or regulations.

SIGNATURE:

Patient:_____ Date:_____

If other than patient indicate relationship to: __Parent__Guardian / Legal Representative
__Other:_____

Identity of Patient and/or Signature Verified via: ☐ Photo ID ☐ Matching Signature ☐ Other, specify_____

Verified by:_____

2-24-14 _____Date of Authorization Expiration