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) ☐ Telephone Encounters ☐ Laboratory Tests ☐ Progress Notes

☐ X-Ray Reports ☐ Photographs, videotapes, digital or other images ☐ Other _____

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. 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 unless I direct a different expiration date here _____.

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.

If you would like this information to be sent electronically, please check one of the following boxes:

☐ Email Email Address: _____ ☐ Disc

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 ☐ Reviewed Signature ☐ Telephone Call
☐ Other, specify _____

Patient Request verified by: _____ Date: _____