

## **RECORDS RELEASE**

Please fill out this form completely.

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336-3503 • Fax (605) 336-6010 Date needed by: \_\_\_\_\_

Name of Patient (please print full name): Alias: Patient's complete address: Patient's complete address: Patient's date of birth:  Name of person requesting records transfer: (please print full name) Relationship to patient: Phone number where you can be reached for questions:  The records will be SENT FROM: Name: Phone: City, State, Zip: Phone: City, State, Zip: Phone: City, State, Zip: Pax (optional):  The records will be SENT TO: Name: Address: Phone: City, State, Zip: Pax (optional): What information do you want sent? Please check the appropriate boxes. Dictation / Notes OP Reports Alicey Tests Dates: Chry State, Zip: Consults The records will be disclosed because of: The records will be disclosed because of: The records will be sent to the disclosed because of the record will be disclosed because of the disclosed because of the record will be disclosed	Today's Date:(THIS FORM WILL EXPIRE ON	UE YEAR FROM THE ABOVE DA	TE)
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Relationship to patient:  Phone number where you can be reached for questions:  The records will be SENT FROM:  Name:	Patient's date of birth:		
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Allergy Tests Dates: Consults Other: Information will be disclosed because of: Personal reasons Legal issues Transferring care Other: My signature is approval of my authorization. I authorize the above named Medical Practice/provider to release my protected health information to those identified on this release. I understand that if any person receives this information that is not covered by the federal privacy regulation, the release may no longer be protected. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I may revoke this release at any time by a written notification unless action has previously been taken or for obtaining insurance coverage.	<del>-</del>	•	2, 1
Information will be disclosed because of:  Personal reasons Legal issues Transferring care Other:  My signature is approval of my authorization. I authorize the above named Medical Practice/provider to release my protected health information to those identified on this release. I understand that if any person receives this information that is not covered by the federal privacy regulation, the release may no longer be protected. I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I may revoke this release at any time by a written notification unless action has previously been taken or for obtaining insurance coverage.	<del>_</del>	<del>-</del>	_
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Signature of Patient : Date:	mation to those identified on this release regulation, the release may no longer be I understand the information in my heal ciency syndrome (AIDS) or human immices and treatment for alcohol and drug I understand once the information below federal privacy laws or regulations. I may revoke this release at any time by	e. I understand that if any person receive protected.  Ith record may include information relatinunodeficiency virus (HIV). It may also abuse.  It is released, it may be re-disclosed by the a written notification unless action has provided the second content of th	ing to sexually transmitted disease, acquired immunodefi- include information about behavioral or mental health serv- ne recipient and the information may not be protected by previously been taken or for obtaining insurance coverage.
	Signature of Patient :	minor under age of 18 guardian's signatur	Date: