DIAMOND FAMILY MEDICINE

904 Quincy Street, Rapid City, SD

Phone: 605-716-6656 ♦ Fax: 605-716-6623

Patient's Name: _____

Today's Date: _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY/FRIENDS

I _____ give permission to Diamond Family Medicine to disclose and release my protected health information described below to:

NAME	PHONE NUMBER	RELATIONSHIP

Health information to be disclosed (check all that apply):

☐ My complete health records- including but not limited to diagnoses, lab and diagnostic test results, prognosis, treatment, and billing information for all conditions **OR**

☐ My complete health record, as above, with the exception of the following information:

- ☐ Mental Health
- ☐ Communicable diseases (i.e. STD's, HIV)
- ☐ Other (specify): _____

This health information may be used to enable the person(s) I authorize to know and understand my condition, treatment, treatment options, treatment consultations, and payment purposes.

This authorization shall be effective for all past, present, and future information. I understand I may revoke this authorization at any time by notifying this office in writing.

_____	_____	_____
Printed Name	**Signature**	**Date**