

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date: _____

Date of Birth: _____ SSN#: _____ Date Needed By: _____

Address: _____

RELEASE RECORDS TO
Kenneth Diamond, MD
904 Quincy Street, Rapid City, SD 57701
Phone: 605-716-6656 ♦ Fax: 605-716-6623
(Complete Section Below)

SEND MEDICAL RECORDS TO
(Complete section below)

Receiving Records From/Sending Records To:

Dr/Clinic/Hospital: _____ Address: _____

City/State/Zip: _____ Phone #: _____ Fax #: _____

Purpose of Release: Request of Patient Continuity of Care Legal Other

Records Requested: Please check all boxes that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Hospital/Surgical Reports |
| <input type="checkbox"/> Cardiology/EKG | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Prescription/Medication List |
| <input type="checkbox"/> Diabetic Records | <input type="checkbox"/> Specific Tests/Records _____ | |

Dates of Service: _____

I understand that my health record may include information relating to behavioral or mental health services, treatment for alcohol and or drug abuse, sexually transmitted disease, Hepatitis B or C testing, AIDS/HIV testing and or diagnosis and I am authorizing the release of that information.

I release the above from all legal responsibility or liability that may arise from the act I have authorized. I understand that this authorization is valid for one year after the date of my signature. I also understand that this authorization can be revoked, except to the extent that action was already taken to comply with the release.

Signature of Patient/Legal Representative

Date

Relationship to Patient

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making further disclosure of it without the specific written consent of the person whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of this medical or other information is not sufficient for that purpose.