

PEDIATRICS PLUS

1200 E 6th AVE

Mitchell SD 57301

Phone # 605-996-3380

Fax # 605-996-3385

Patient Name

Date of Birth

Please choose one of the following:

Release information to:

Obtain information from:

Treatment dates: _____

Purpose of request: _____

Please check all that apply:

- physician notes
- lab results
- x-ray reports
- complete record
- other _____

I understand that any disclosure of information carries with it the potential for redisclosure and that the information then may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. And I understand that the revocation will not apply to information already released based on this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment.

It is my understanding that this information will be confidential and will not be shared with any unauthorized person without my written consent. This authorization to release / obtain information shall be in effect for six (6) months.

Expiration Date ____ / ____ / ____

Patient/Parent/Guardian Signature

Date

FOR OFFICE USE ONLY

Date _____ Initials _____

Fax _____ Mail _____

Release.03