

**AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

Daytime phone number or number where you can be reached (\_\_\_\_\_) \_\_\_\_\_

**1. REQUEST RECORDS FROM**

- Dakota Radiology, 2929 5th Street, Suite 100, Rapid City, SD 57701
- Other

**2. RELEASE RECORDS TO**

- Dakota Radiology, 2929 5th Street, Suite 100, Rapid City, SD 5770`
- Patient (at the same address as above)
  - By Mail
  - For Pickup
- Other (include name, address, phone#) \_\_\_\_\_

**3 PURPOSE**

- At the request of the patient
- Continued Care
- Attorney
- Finance
- Other \_\_\_\_\_

Covering the dates of service FROM \_\_\_\_\_ TO \_\_\_\_\_

**4. I would like the following information released:**

\_\_\_\_\_

5. Without my express revocation, this authorization will expire in 180 days from date of signature. 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.

- A. 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, except to the extent that action has already been taken to comply with it.
- B. 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.
- C. Re-disclosure, I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations.

**6. SIGNATURE Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

**Please FAX this form to the Records Management Department at 605-342-3930.**