Authorization for Use and Disclosure of Protected Health Information.

Patient Name ______________________________ **DOB** ______________

Date Information Needed By: ______________________________

Patient Address: ______________________________

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Daytime Phone Number where you can be reached: ______________________________

Please Release Records to:

- ☐ Dakota Radiology 2929 5th St; Suite 100; Rapid City, SD 57701
  Phone: 605-342-2852; Fax: 605-342-3930
- ☐ Patient at the Address above
- ☐ For Pick-up - Provide name of person picking up ______________________________
- ☐ Other (Include Facility Name, Address, Phone #, Fax #
  - Facility ______________________________
  - Address ______________________________
  - Phone# ______________ Fax # ______________

Requesting Records from:

- ☐ Dakota Radiology
- ☐ Other (Include Facility Name, Address, Phone #, Fax #
  - Facility ______________________________
  - Address ______________________________
  - Phone# ______________ Fax # ______________

Exam Type(s): ______________________________

Dates of Service: ______________________________

Purpose

- ☐ Patient Request
- ☐ Continued Care
- ☐ Attorney
- ☐ Other ______________________________

Without my express revocation, this authorization will expire in 180 days from the date of signature. I understand that I may revoke this authorization at any time by submitting my request in witing except to the extent that action has already been taken to comply with it.

Signature ______________________________ **Date** ______________

If other than patient, indicate relationship (circle one): Parent | Guardian | Legal Rep | POA | Medical Records