CENTER FOR FAMILY MEDICINE

AUTHORIZATION FOR RELEASE, USE, OR DISCLOSURE OF HEALTH INFORMATION

1115 E. 20th Street
Sioux Falls, SD 57105
www.centerforfamilymed.org

Patient Identification

*Patient Name: _____ DOB: _____
(Last) (First) (MI)

Address: _____ Phone: _____

City/State/Zip: _____

Maiden/Previous Names/Nickname: _____ Social Security Number: _____

Provider *(Who is releasing information?)*

Provider/ Facility Name: _____

Address: _____ Phone: _____

City/ State/ Zip: _____ Fax: _____

Disclose Information To: *(Where is information to be sent?)*

Center for Family Medicine
1115 E. 20th Street
Sioux Falls, SD 57105

Phone: 605-339-1783
Fax: 1-888-869-1341

***Information to be Disclosed**

- ☐ All Records
- ☐ X-Ray Reports
- ☐ History and Physical
- ☐ Lab Reports
- ☐ Visit Notes
- ☐ Other

Specify "Other" below: _____

Requested Dates of Information

******* ONLY RECORDS FOR THE LAST 2 YEARS WILL BE RELEASED IF DATES ARE NOT SPECIFIED *******

From: _____ To: _____

Purpose of Disclosure *(Please be specific)

- ☐ Continuing Medical Care
- ☐ Consult/Second Opinion
- ☐ Out-of-Town Move
- ☐ Insurance Claim
- ☐ Legal
- ☐ Personal
- ☐ Other (Specify): _____

Expiration Date

*This authorization will expire one year from the date of signature, or on _____.

Revocation

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) Action was previously taken in reliance on this authorization; or (2) This authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Authorization

I hereby authorize the above facility/provider to disclose medical/dental information concerning the above-named patient to the party identified in the section entitled, "Disclose Information To." I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

_____ _____
*Signature of Patient/Representative *Signature Date

_____ _____
Relationship to patient, if signed by representative Witness

Please supply proof of authority to act if other than patient. For minors, proof is only required if other than parent.

Disposition

—For office use only—

☐ Authority to act attached * ☐ ID validated by: _____ Patient No.: _____

☐ To be picked up ☐ To be mailed ☐ To be faxed ☐ To be sent in electronic format

☐ Request completed by: _____ Date completed: _____

*Indicates required field

Revised 10/9/2026