Rushmore Obstetrics & Gynecology

3006 Tower Road
Rapid City, SD 57701
Phone (605) 343-7295
Fax (605) 343-0138
www.rushmoreobgyn.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use/disclosure of my health information as described below. I understand that this authorization is voluntary. I understand that any and all records, whether written, oral, or electronic format are confidential and cannot be disclosed without my prior written authorization except as otherwise provided by law. I understand that a photocopy or fax of this authorization is as valid as the original.

I understand that I may revoke this authorization at any time; except to the extent that records or information have already been provided to/from Rushmore OB/Gyn. I understand that once Rushmore OB/Gyn receives records (if applicable), they will be protected by the Privacy Rule. I understand that if I am authorizing Rushmore OB/Gyn to release information to another entity that is not bound by the Privacy Rule, the information is no longer protected by the Privacy Rule and that entity may re-disclose the information. This authorization will expire once the information has been released or received or 1 year after the date of the said authorization.

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **SSN:** _____

PLEASE RELEASE RECORDS FROM:

Name_____

Address: _____

Phone: _____ Fax: _____

PLEASE RELEASE RECORDS TO:

Name_____

Address: _____

Phone: _____ Fax: _____

INFORMATION REQUESTED:

- ☐ Entire Medical Chart (may include STI, HIV/AIDS, Mental Health, Alcohol, Drug records)
- ☐ Record of Visit (Specific)_____
- ☐ Operative Report(s)_____
- ☐ Laboratory Report(s)_____
- ☐ Other_____

REASON FOR THE DISCLOSURE:

☐ Continuing Medical Care	☐ Second Opinion
☐ Out of Town Move	☐ Insurance Claim
☐ Personal	☐ Legal

_____ _____

SIGNATURE OF PATIENT OR REPRESENTATIVE DATE/TIME