The Rehab Doctors P.C.

1136 Jackson Boulevard
Rapid City, South Dakota 57702
(605) 721-7246 • Fax (605) 341-4501

Authorization for Release of Medical Information

Signature of the patient is required for all patients 18 years of age or older. A parent or legal guardian may provide the authorizing signature if the patient is a minor. If the patient is deceased, the next of kin, administrator, or executor of the estate may sign the authorization.

I hereby authorize _____ to release medical information on:
(Name of Healthcare provider releasing this information)

Address:_____ Fax:_____

Patient Name:_____ SSN:_____

Previous or Maiden Name:_____ Date of Birth:_____

To: <u>The Rehab Doctors, P.C.</u>

Information to be released: _____

This information to be released for the following purpose: _____

Date of actual or approximate dates of service:_____ to _____

I hereby give special permission to release any information regarding the following (Check any box(es) below that you grant _____ _____ permission to release):

- ❍ Acquired Immunodeficiency Syndrome (AIDS)
- ❍ Infection with Human Immunodeficiency Syndrome (HIV)
- ❍ Treatment for Alcohol and/or Drug Abuse
- ❍ Psychiatric/Mental Health Information
- ❍ Physical Abuse/Sexual Abuse
- ❍ Sickle Cell Anemia

The special authorization above allows _____ to disclose information protected under federal law relative to alcohol and drug related diagnosis and treatment, or allows them to specifically inform you that the medical record contain information specific to HIV, AIDS or Sickle Cell Anemia.

I make this consent upon the promise that all disclosure made according to the authority granted by this consent shall be accompanied by a written notice stating:

This information has been disclosed to you from records protected by Federal Confidentially Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for the purpose.

I understand this authorization may be revoked, in writing, at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____ _____ (If left blank, this authorization will automatically expire one year from the date signed below.) I do not authorize further release to any other third party.

I hereby release _____, its employees, officers and physicians from all legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of patient, parent/guardian or legal representative | Date Signed

_____ _____
Street Address | City/State/Zip

_____
Relationship if NOT the patient