The Rehab Doctors PC

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. This authorization excludes all hospital records and records from other physicians or healthcare facilities.

I hereby authorize The Rehab Doctors, P.C. to release medical information on:

Patient Name: Harley Glayzer SSN: 503-35-0093

Previous or Maiden Name: N/A Date of Birth: 12-12-2002

Please release this information to: Harley J Glayzer
(Name of Physician, Hospital, healthcare provider or facility, etc.)

1515 East Saint Patrick Street Lot 238 Rapid City, SD 57703
(Street Address) (City/State/Zip)

Information to be released: All Information

This information to be released for the following purpose: Knowlege of own medical information

Date of actual or approximate dates of service: 2021 to 2023

I hereby give special permission to release any information regarding (Check any box(es) below that you grant permission to release information to The Rehab Doctors, P.C.) the following:

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

The special authorization above allows The Rehab Doctors, P.C. and/or its agents 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 contains information specific to HIV, AIDS or Sickle Cell Anemia.

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

This information has been disclosed 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: January 1st, 2050 (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 The Rehab Doctors, P.C. and its agents, its employees, officers and physicians from all legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Harley J Glayzer
Signature of patient, parent/guardian or legal representative

09-19-2023
Date Signed

1515 East Saint Patrick Street Lot 238
Street Address

Rapid City, SD 57703
City/State/Zip

Relationship, if NOT the patient