Black Hills Obstetrics & Gynecology LLP.

677 Cathedral Drive Rapid City, SD 57701

Phone (605) 343-9224 Fax (605) 342-1359

Authorization for release of Medical Records

(All information must be filled out for release to be valid)

Patient Name (Print) : _____ Account # _____

(First) (M Initial) (Last)

Date of Birth: _____ Social Security # : _____ Current Phone # _____

Patients Address: _____

(Street Address) (City) (State) (Zip)

Date of Request: _____ Date Needed By:_____

RELEASE RECORDS FROM:

Physician: _____ Clinic/Hospital _____

Address: _____ Phone _____ Fax _____

RELEASE RECORDS TO: ☐ Self ☐ Mail ☐ Fax ☐ Pickup

Physician: _____ Clinic/Hospital _____

Address: _____ Phone _____ Fax _____

Purpose for releasing medical information: _____

Black Hills Obstetrics & Gynecology LLP will release only medical information documented /dictated on treatment received at this facility. If you have been treated at another facility please contact them to make arrangements.

I understand that this release of medical records may contain information regarding drug or alcohol abuse, mental health issues and/or HIV (AIDS) and STD (Sexually Transmitted Diseases)

Please send copy of records as indicated:

☐ All Records (Including but not limited to Mental Health, STD, HIV/AIDS, Alcohol/Drug, & Disability)

Or, select specific records as below:

☐ Clinic Notes ☐ Mental Health ☐ Pap/Birth Control ☐ STD Records

☐ HIV/AIDS ☐ Alcohol/Drugs ☐ Pre-Natal ☐ Immunizations

☐ Labs ☐ Mammo/Ultrasound ☐ Other _____

Signature of Patient _____ Date: _____

Signature of Guardian or Legal Representative _____ Date: _____

Witness _____ Date: _____

This authorization expires one year from the date of signature unless revoked in writing prior to expiration date.