YANKTON MEDICAL CLINIC®, P.C.

0253-27R3 / FORM 172

AUTHORIZATION FOR RELEASE OF INFORMATION

www.YanktonMedicalClinic.com
www.VermillionMedicalClinic.com

☐ Yankton Medical Clinic, P.C.
1104 W. 8th Street, Yankton, SD 57078
PH 605-665-7841 • FAX 605-665-0546

☐ Vermillion Medical Clinic
101 S Plum, Vermillion, SD 57069
PH 605-624-8643 • FAX 605-624-2362

Individual Information: **Signature of the patient is required of all patients 18 years of age or older.** A parent or legal guardian may provide authorizing signature if the patient is a minor or when patient is physically or mentally incompetent.

Patient Name:______________________ Phone: (________)______________________

Address:______________________

Patient Date of Birth: ______ / ______ /______ Patient Chart #: ______________________

Information may be disclosed by: *(Who is releasing the information)*

The following individual or organization is authorized to make the disclosure - ***YOU MUST SUPPLY AN ADDRESS***

Name:______________________

Phone: (________)______________________ Fax: (________)______________________

Address:______________________

Information may be disclosed to: *(Where info is to be sent)*

This information may be disclosed to and used by the following individual or organization:

Name:______________________

Phone: (________)______________________ Fax: (________)______________________

Address:______________________

Information to be disclosed: *(Include date of service needed)*

☐ Entire Record		☐ X-ray and imaging reports	______ / ______ /______
☐ Other	______________________	☐ EKG	______ / ______ /______
☐ History and Physical	______ / ______ /______	☐ Operative Report	______ / ______ /______
☐ Discharge Summary	______ / ______ /______	☐ Pathology Report	______ / ______ /______
☐ Lab	______ / ______ /______	☐ Pediatric Growth Chart	

Date information is needed: ______ / ______ /______ Tricare recipient: ☐Yes ☐No

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, or treatment for alcohol and drug abuse.

For the purpose of (purpose not required for personal requests):

A copying fee may be charged on requests for purposes other than patient care.

☐Continued Healthcare ☐Personal ☐Other: ______________________

I understand that I have a right to revoke this authorization at any time. I understand that, if I revoke this authorization, I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition ______________________. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign the authorization. I need not sign this form to assure treatment. I understand that I may review or copy information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of it carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about the disclosure of my health information, I can contact the Privacy Officer at the Yankton Medical Clinic, P.C.

______________________ Date: ______ / ______ /______
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

____
PRINT

______________________ ______________________
RELATIONSHIP TO PATIENT WITNESS

FAILURE TO COMPLETE IN FULL MAY RESULT IN DELAY OF PROCESSING.