



YANKTON MEDICAL CLINIC®, P.C.

RELEASE OF AUTHORIZATION FORM

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

Yankton Medical Clinic, P.C. Ear, Nose & Throat
2525 Fox Run Parkway, Suite 101, Yankton, SD 57078
PH 605-665-0062 • FAX 605-665-0076

Yankton Medical Clinic, P.C. Norfolk Ear, Nose & Throat
301 N. 27th Street, Suite 4, Norfolk, NE 68701
PH 402-844-8110 • FAX 402-844-8113

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

Name: \_\_\_\_\_
Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_
Address: \_\_\_\_\_

Information to be disclosed:
[ ] 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.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

PRINT

RELATIONSHIP TO PATIENT

WITNESS