

Medical Clinic 605-367-8793  
FAX 605-367-8247—Medical Records  
FAX 605-367-8211—Nursing

Dental Clinic 605-367-8022  
FAX 605-367-8001

City of Sioux Falls  
TTY/Hearing Impaired 605-367-7039



521 North Main Avenue  
Sioux Falls, SD 57104  
www.siouxfalls.org

### Authorization for Release of Information

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Patient No. \_\_\_\_\_  
Last First MI

Falls Community Health Provider: \_\_\_\_\_

I hereby authorize Falls Community Health (FCH) to release any information, including the diagnosis and records of any treatment or examination rendered to me. In addition, I also authorize return release of information to FCH from the referral individual, agency or other entity listed below, including the diagnosis and records of any treatment or examination rendered to me. FCH is not financially or otherwise responsible for services I receive from another individual, agency, or other entity.

Individual, agency, or other entity: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

- General Medical Information
- General Dental Information
- Mental Health Treatment
- Other: Specify. (Give dates if specific information is requested.) \_\_\_\_\_

- Drug or Alcohol Abuse
- Lab, X-ray
- HIV Related Information

This authorization is effective for ninety (90) days from the date it was signed. I understand I may revoke this authorization at any time by giving written notice to FCH, except to the extent that action has already been taken in reliance upon it. I understand I have the right to inspect the information to be disclosed. A photocopy of this document shall be deemed equivalent to the original, signed document. Access will be granted within 30 days of signature unless you are otherwise notified.

#### SPECIFIC AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION AND/OR DRUG ABUSE INFORMATION AND/OR HIV INFORMATION.

I acknowledge that data to be released MAY INCLUDE material that is protected by federal law and that is applicable to EITHER mental health information, Drug/alcohol abuse or HIV information. My initials authorize release of all information regarding the specific information.

\_\_\_\_\_  
(Signature) (Date)

\_\_\_\_\_  
(Relationship, If Not Patient)

\_\_\_\_\_  
(Witness)

- \_\_\_\_\_ Mental health information
- \_\_\_\_\_ Drug/Alcohol abuse information
- \_\_\_\_\_ HIV information

\_\_\_\_\_  
(Signature) (Date)

In order for the above information to be released, you must Initial each line accepted and sign here.

#### OPTIONAL REFERENT INFORMATION

Maiden or Other Name: \_\_\_\_\_

Former Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

#### FALLS COMMUNITY HEALTH USE ONLY

- This is a request to SEND records
- Process immediately
- Appointment pending
- Checked ID if other than patient
- This is a request to RECEIVE records
- File in chart only
- Expiration date \_\_\_\_\_