Authorization to Release Protected Health Information

2001 Broadway Avenue, Yankton, SD 57078
Phone: 605-689-2273 Fax: 605-689-0393

806 8th Street, Springfield, SD 57062
Phone and Fax: 605-369-2306

Release Information From:	**Release Information to/Provide Authorization For:**
○ Quality Health Clinic - Yankton, SD 57078 ○ Quality Health Clinic - Springfield, SD 57062 ○ Authorized individual or facility *(Specify facility/individual & address below, including phone/fax if known)* ____________________ ____________________ ____________________	○ Quality Health Clinic - Yankton, SD 57078 ○ Quality Health Clinic - Springfield, SD 57062 ○ Authorized individual or facility *(Specify facility/individual & address below, including phone/fax if known)* ____________________ ____________________ ____________________

Purpose of Release/Authorization:

○ Treatment/Continued care	○ Legal Purpose	○ Coordinate Appointments	○ Discuss My Medical Plan
○ Application for insurance	○ Payment of Insurance Claim	○ Pick Up Prescriptions	○ Mutual Exchange of Information
○ Personal	○ Disability Determination		
○ Other			

Information to be Released:

Service Dates From____________	**To**____________	**Information Needed By:**____________	
○ History and Physical	○ EKG's	○ Laboratory Reports	○ Hospital Discharge Summary
○ Immunization Records	○ Pathology Reports	○ Radiology Reports	○ Billing information
○ Outpatient Clinic Notes	○ Operative Notes	○ Radiology Images	○ Other
○ All Records x two years	○ ER Reports	○ Hospital Notes	

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. This authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law.

This authorization will expire once records have been obtained or one year from the date of signing, unless an earlier date or event is indicated here:____

ATTENTION: This is a legal document. Please read carefully. By signing you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship.
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.

Signature (Required)		**Date Signed** (Required) (Month, DD, YYYY)	
Printed name of person signing (Relationship if other than patient)			
Mailing address of patient (Street or PO Box)			
City	**State**	**Zip Code**	**Phone**