WOMEN'S WELLNESS CENTER
Obstetrics • Gynecology • Infertility • Osteopathy
142 3rd St SE Suite 2 Huron, SD 57350
P: 605.554.1020 F: 605.554.1021

Medical Records Release

Name: _____ DOB: _____

Maiden (Previous) Name: _____

Authorization
I hereby authorize my physician and/or the administrative and clinical staff at: (from)
to use and/or disclose my protected health information to: (to)

Protected Health Information to be Used or Disclosed: (please initial)	
_____ All Medical Records	_____ Lab Results
_____ X-ray Reports	_____ Progress Notes
_____ Other: _____	

Do Not Disclose:	
_____ HIV/STD Results	_____ Other: _____

Reason For Use or Disclosure:	
_____ Second Opinion	_____ Relocating
_____ Continuing Medical Care	_____ Other: _____

This authorization is also subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance to this authorization.
I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

Authorizing Signature:

I certify that the information listed above is correct to the best of my knowledge, and that I am giving this authorization voluntarily. By signing as personal representative to the patient, I certify that I have legal authority to do so.

Signature: _____ Date: _____

Relationship to Patient: _____

This authorization will expire one year from the date of signature or on _____.