Sioux Falls
CENTER FOR
PLASTIC &
RECONSTRUCTIVE
SURGERY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

NAME OF PATIENT _____ DATE OF BIRTH _____

PREVIOUS NAME (if applicable) _____

I hereby authorize Sioux Falls Center For Plastic & Reconstructive Surgery or _____ to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary. My health care and payment for health care services provided by you will not be affected if I do not sign this form. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may be redisclosed and may no longer be protected by federal privacy regulations.

I request and authorize you to release the specified information to the person or organization named on this request. I understand if I request "all records" be released, all of the information in my medical records will be provided including: treatment other than as relates to any current medical condition; care and treatment provided by other health care providers; records concerning alcohol or drug treatment evaluation or treatment; and mental health records.

Specific description of information that may be disclosed (include treatment dates, if applicable):

_____ All Records (including x-rays)
_____ History and Physical
_____ Discharge Summary
_____ Laboratory Reports
_____ X-ray Reports
_____ X-Rays
_____ Operative Report(s)
_____ Pathology Report(s)
_____ Doctor/Clinic Notes
_____ Other _____

_____

I specifically request that the above information be released to:

Dr. Richard J Howard M.D.
6301 S. Minnesota Ave #300
Sioux Falls, SD 57108
Telephone: 605-334-1930
Fax: 605-334-0926

OR _____

_____

_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on the following date or event: _____. Initials: _____
2. I understand that I may revoke this authorization at any time by notifying Richard Howard, MD in writing, but if I do it will not have any effect on any actions taken before revocation is received. Initials: _____

_____ _____

Signature of patient or patient's representative (Form MUST be completed before signing) Date

Printed name of patient's representative (if applicable): _____

Relationship to the patient: _____

* I MAY REFUSE TO SIGN THIS AUTHORIZATION *