Faulkton Area Medical Center
1300 Oak Street, PO Box 100
Faulkton, SD 57438

Authorization for Release of Medical Information

Patient Name: _____ Date of Birth: ____/____/_____
Maiden Name or any Previous Names: _____

I hereby request and authorize:
Name of Facility: _____
Address: _____
City: _____State: _____ Zip: _____
Phone: _____Fax: _____

To Release Information from my MEDICAL RECORD TO:
Name of Facility: _____
Address: _____
City: _____State: _____ Zip: _____
Phone: _____Fax: _____

Purpose of Disclosure: _____
Dates of Service: _____

Information to be Released

__ History & Physical __ Discharge Summary __ ER Report __ Lab Results
__ Consultation Reports __ Operative Reports __ Clinic Notes __ X-Ray Reports
__ Pathology Reports __ Autopsy Reports __ Therapy Reports __ Nutrition Consults
__ Other: _____

I understand the record may include information regarding Drug and/or Alcohol Abuse, HIV testing, or Mental Health records. I acknowledge that such information is protected by Federal and/or State law. I release the above from all legal responsibility or liability that may arise from the act I have authorized.

This authorization shall be in effect for twelve months from this date, unless revoked by myself.

_____ _____
Patient/Representative Signature & Date Witness Signature & Date

_____
*Relationship to Patient

*Authorization must be signed by the PATIENT, patient representative, or legal guardian if patient is physically or mentally unable to sign.