DAKOTA VASCULAR
Complete Vascular Care

# RELEASE OF MEDICAL INFORMATION

Patient First Name: _____
Patient Last Name: _____
Date of Birth: _____

## REQUESTED RECORDS FROM

Name of Provider: _____
Provider E-mail: _____
Provider Phone: _____
Provider Fax: _____
Address: _____
City, State, Zip Code: _____

## SEND RECORDS TO

Name of Recipient: **Dakota Vascular**
Provider E-mail: **info@dakotavascular.com**
Provider Phone: **605-306-6100**
Provider Fax: **605-306-6500**
Address: **3801 S. Elmwood Ave, Sioux Falls, SD 57105**

## INFORMATION TO BE DISCLOSED

**I authorize the release of the following health information:**

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.

Only the certain records or types of health information:

_____

_____

## TERM

**Please choose one:**

I understand that this Authorization will remain in effect:

- Until the provider fulfills this request.
- From the date of this authorization for one year

## REDISCLOSURE

I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

## REFUSAL TO SIGN/RIGHT TO REVOKE

I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

## AUTHORIZATION

I, ***(Patient Name)_____,*** authorize (***Name of Provider)_____*** to release confidential health information about me. You may release a copy of my medical records, or a summary or narrative of my protected health information to ***Dakota Vascular.***

Patient First Name: _____
Patient Last Name: _____

Signature: _____
Date: _____

**If Individual is unable to sign this Authorization, please complete the information below:**

Name of Guardian: _____
Relationship: _____