



INTERNAL USE ONLY

Patient Name _____
Chart/Account # _____ DOB _____
Doctor _____
Date _____

RELEASE OF INFORMATION

Patient Name _____ Date of Birth _____

Address _____

Hospitalization / Appointment Date: _____

I hereby authorize to release information from the medical record as follows:

Name: _____

Address: _____

- Checkboxes for: Allergy Testing, Allergy Consultation, ENT Consultation, Sinus CT, History and Physical, Discharge Summary, Laboratory Reports, X-Ray Reports, Operative Report(s), Pathology Reports(s), Entire Record, Other

I specifically request that the above information be released to:

Dakota Allergy & Asthma
2200 West 49th St, Sioux Falls, SD 57105

for the purpose of:

- Checkboxes for: Continued Health Care, Completion / Payment of Hospital Insurance Claim, Other

I understand that the information to be released may include information regarding drug abuse and/or alcoholism or alcohol abuse.

This authorization shall be in effect for one year from this date, unless revoked by me in writing at any time, except to the extent that action has already been taken to comply with it.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

Date _____ Information Sent _____