INTERNAL USE ONLY
Patient Name ______________________________
Chart/Account # ______________ DOB __________
Doctor ___________________________________
Date _____________________________________

RELEASE OF INFORMATION FROM DAKOTA ALLERGY & ASTHMA

Patient Name ____ Date of Birth _____________________________

Address ____

Hospitalization / Appointment Date: ____

I hereby authorize Dakota Allergy & Asthma | 2200 West 49th St, Sioux Falls, SD 57105 to release information from the medical record.

- ☐ 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 ___________________

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I specifically request that the above information be released to:

Name: ____

Address: ____

for the purpose of:

- ☐ 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 ____

605-336-6385 Fax 605-336-6513
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Mark E. Bubak, MD | Lindsey R. Peterson, CNP