Rapid City Obstetrics & Gynecology LLC
7236 Jordan Dr., Ste 100, Rapid City, SD 57702
Phone (605) 718-3747 • Fax (605) 718-3047

Authorization for Release of Medical Records

(All information must be filled out for release to be valid)

Patient Name (Print): _____ Social Security # : _____
(First) (M Initial) (Last)

Date of Birth: _____ Date of Request _____ Date Needed By: _____

Patients Address: _____
(Street Address) (City) (State) (Zip)

Current Phone Number: (_____)_____

RELEASE RECORDS FROM:

Physician: _____ Clinic/Hospital _____

Address: _____ Phone/Fax _____

RELEASE RECORDS TO: ☐ SELF ☐ MAIL ☐ PICKUP ☐ FAX

Physician: _____ Clinic/Hospital _____

Address: _____ Phone/Fax _____

Purpose for releasing medical information:_____

Rapid City Obstetrics & Gynecology LLC will release all medical information including any outside facility medical records which we have received.

I understand that this release of medical records may contain information regarding drug or alcohol abuse, mental health issues and/or HIV (AIDS) and STD (Sexually Transmitted Diseases)

Please send copy of records as indicated:

☐ All records (Including but not limited to Mental Health, STD, HIV/AIDS, Alcohol/Drug, & Disability) to include all outside facility records.

Or, select specific records as below:

☐ Clinic Notes	☐ Mental Health	☐ Pap/Birth Control	☐ STD Records
☐ HIV/AIDS	☐ Alcohol/Drugs	☐ Pre-Natal	☐ Immunizations
☐ Labs	☐ Mammo/Ultrasound	☐ Other _____	

Signature of Patient _____ Date: _____

Signature Guardian or Legal Representative _____ Date: _____

This authorization expires 1 year from the date of signature unless revoked in writing prior to expiration date.