DAKOTA CARDIOVASCULAR, P.C.
343 QUINCY STREET, SUITE 104
RAPID CITY, SD 57701
PHONE (605) 341-1300 FAX 341-8785

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTY

This form is for use by a patient or legal representative to authorize release of information to a third party medical provider for continuation of care.

Patient name (*first, middle, last*)	**Birthdate** (*mm-dd-yyyy*)
Address (*Street, city, ZIP code*)	
Date of request	
Release Information FROM: Dakota Cardiovascular, PC 343 Quincy #104 Rapid City SD 57701	**Release/Send Information TO:** (Clinic)__________ (Street)__________ (City)__________ (State)_____ (ZIP code)______ Phone__________ FAX__________
This authorization will expire 1 year from the date of signature	

The patient or legal representative must sign and date this authorization.

- This authorization may be revoked at any time by providing a written notice of revocation except to the extent that the Providers have already taken action in reliance on it.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- I may request a copy of the signed authorization.
- I may be charged for copies in accordance with state law.
- I have a right to inspect and receive a copy of the material to be disclosed.

Note: A patient18 years or older on the date of this request must authorize the release of their own information unless patient is incapacitated or deceased.

SIGNATURE (required) ▶	**DATE** (required; *mm-dd-yyyy*)
If not patient Printed name of person signing (*first, middle, last*)	Relationship to patient
If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Legal documentation of the right of access by the signing individual (other than patient) may be required (stepparent, legal guardian, foster parent, healthcare power of attorney/agent).	