CREEKSIDE MEDICAL CLINIC

2822 Jackson Blvd, Suite 101
Rapid City, South Dakota 57702
(605) 341-1208 office (605)341-3552 fax
www.CreeksideMedicalClinic.org

AUTHORIZATION TO RELEASE INFORMATION

Patient's Full Legal Name _____ Daytime Phone Number _____ DOB (mm/dd/yyyy) _____

Mailing Address _____ City & State _____ Zip Code _____

NO CDs PLEASE - Creekside Medical Clinic sends and accepts faxed or paper medical records only.

Indicate Provider:

- ☐ Nancy Babbitt, MD
- ☐ Jon Wingert, MD
- ☐ Carson Phillips, MD
- ☐ Ann Hibbs, MD
- ☐ Taylor Kapsch, MD
- ☐ Kyle Larson, DO
- ☐ Jenna Dormann, PA-C
- ☐ Steve Sachs, PA-C

Records Requested:

- ☐ All Records
  (Unless otherwise indicated, send **LAST 2 YEARS ONLY**): _____
- ☐ Labs
  Specify: _____
- ☐ Pathology Report(s)
  Specify: _____
- ☐ Images:
  Specify: _____
- ☐ Colonoscopy/EGD Report
  Approximate year if known: _____
- ☐ Other: _____

☐ I request my records be **sent FROM** the following facility:

Name of Provider or Facility _____

City and State _____ Fax Number _____

☐ I request my **CMC records be sent TO** the following facility:

Name of Provider or Facility _____

City and State _____ Fax Number _____

I understand that the information in my health record may include information relating to sexually transmitted disease, HIV-related information, behavioral or mental disorders, and treatment or use of alcohol or other drug abuse.

This authorization expires on _____. If left blank, this authorization is valid up to 10 years. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date of notification.

_____ _____

Signature of Patient or Personal Representative **Date MM/DD/YYYY**