Denton Combs
Center For Excellence In Care

Phone: 605-274-3898 • Fax: 605-274-3899
5124 S. Western Avenue, #4
Sioux Falls, SD 57108

RECORDS RELEASE

Please fill out this form completely.
We require at least 24 hours to complete your request.

Date needed by: _____

Today's Date: _____
(THIS FORM WILL EXPIRE ONE YEAR FROM THE ABOVE DATE)

Name of Patient (please print full name): _____

Patient's complete address: _____

Patient's date of birth: _____

Name of person requesting records transfer: *(please print full name)* _____

Relationship to patient: _____

Phone number where you can be reached for questions: _____

The records will be **SENT FROM:**

Name: _____ Facility: _____

Address: _____ Phone: _____

City, State, Zip: _____ Fax (optional): _____

The records will be **SENT TO:**

Name: DENTON COMBS Facility: Denton Combs Center

Address: 5125 S. Western Avenue, Suite 4 Phone: 605-274-3898

City, State, Zip: Sioux Falls, SD 57108 Fax (optional): 605-274-3899

What information do you want sent? Please check the appropriate boxes.

- ❑ Dictation / Notes
- ❑ Labs
- ❑ Allergy Tests
- ❑ OP Reports
- ❑ Audio
- ❑ Dates: _____
- ❑ Radiology / Reports
- ❑ Med lists
- ❑ Consults
- ❑ Other: _____

Information will be disclosed because of:

- ❑ Personal reasons
- ❑ Legal issues
- ❑ Transferring care
- ❑ Other: _____

My signature is approval of my authorization. I authorize the above named provider to release my protected health information to those identified on this release. I understand that if any person receives this information who is not covered by the federal privacy regulation, the release may no longer be protected. I may revoke this release at any time by a written notification unless action has previously been taken or for obtaining insurance coverage.

Signature of Patient : _____ Date: _____
(if minor under age of 18, guardian's signature)