HOMETOWN FAMILY HEALTH

Hometown Family Health PLLC
104 W Commerce St/PO Box 35
Plankinton SD, 57368
605.299.8234 (P) 833-982-0180(F)

RELEASE OF MEDICAL INFORMATION AUTHORIZATION

Patient Name: _____

Address: _____ **City:**_____ **State:**_____ **Zip**_____

Phone:_____ **Date of Birth:** _____/_____/_____ **Social Security:** _____

I hereby authorize the release of my protected health information as indicated below:

RELEASE INFORMATION FROM:	**RELEASE INFORMATION TO:**
Provider/Facility: _____ Address: _____ City/State/Zip: _____ Phone: _____Fax: _____	Provider/Facility: Hometown Family Health PLLC Address: 104 W Commerce St/PO Box 35 City/State/Zip: Plankinton, SD 57368 Phone: 605.299.8234 Fax: 833.982.0180

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

☐ **ENTIRE RECORD** ☐ **PROGRESS NOTES** ☐ **DIAGNOSTIC IMAGING** ☐ **IMMUNIZATIONS**

☐ **FAMILY PLANNING** ☐ **DENTAL RECORDS** ☐ **MENTAL HEALTH RECORDS** ☐ **LAB RESULTS**

☐ **OTHER (PLEASE SPECIFY):** _____

☐ **I do NOT wish to release records containing any information related to the treatment or diagnosis of these specified conditions:** _____

PURPOSE OF DISCLOSURE (Changing physicians, continuation of care etc.): _____

REQUESTED DATES OF INFORMATION: _____ **to** _____

(records from the past 5 years will be released if not further specified)

- **I acknowledge that I have the right to revoke authorization at any time, except for information that has already been released under receipt of my previously given authorization. I understand I must revoke this authorization in writing, and both documents will be kept on file by Hometown Family Health**
- **My authorization is valid for 365 days from date of my signature unless specified below**
- **A photocopy or faxed copy of this authorization shall be treated as valid by all parties**
- **Hometown Family Health and all of its representatives are hereby released from any liability or responsibility for disclosure of the above specified information in the designated timeline in accordance with HIPAA**

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name Relationship to Patient