

1720 S. Cliff Ave  
Sioux Falls, SD 57105  
Phone: (605) 334-5630  
Fax: (605) 332-5327

1220 E. Holly Blvd  
Brandon, SD 57005  
Phone: (605) 582-3103  
Fax: Call First



1530 Rowe Ave  
Worthington, MN 56187  
Phone: (507) 372-2232  
Fax: (507) 372-7326

100 West Highway 38  
Hartford, SD 57033  
Phone: (605) 528-1900  
Fax: Call First

*Providing quality Physical, Occupational, Speech and Hand Therapy*

*www.prairierehab.com*

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: \_\_\_\_\_

Previous Name (if applicable): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Patient Address: \_\_\_\_\_

I hereby authorize: Name: \_\_\_\_\_

Address: \_\_\_\_\_

to release information from the medical records as follows:

- |  |  |
|--|--|
| <input type="checkbox"/> All Records (including x-rays)  | <input type="checkbox"/> Therapy Notes/Reports |
| <input type="checkbox"/> History and Physical            | <input type="checkbox"/> X-Rays                |
| <input type="checkbox"/> Discharge Summary               | <input type="checkbox"/> Doctor/Clinical Notes |
| <input type="checkbox"/> Operative Reports               | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> All Dates of Service            |  |
| <input type="checkbox"/> Specific Dates of Service _____ |  |

I specifically request that the above information be released/sent to:

- 1720 S. Cliff Avenue, Sioux Falls, SD 57105  
(605)334-5630 Fax (605)332-5327 \_\_\_\_\_
- 1530 Rowe Avenue, Worthington, MN 56187 OR \_\_\_\_\_  
(507)372-2232 Fax (507)372-7326 \_\_\_\_\_

This authorization shall be effect for one year from this date, unless revoked by me in writing at any time, except to the extent that action has already been taken to comply with it.

Patient Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_