

Health Concepts

5410 Sheridan Lake Rd., Rapid City, SD, 57702

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Medical Records Release

Name (printed) _____

D.O.B. _____

To:

Health Concepts

5410 Sheridan Lake Rd.

Rapid City, SD 57702

Phone (605) 348-4141

Fax (605) 342-7880

Physician: _____

From: _____

(Name)

(Street Address)

(City)

(State)

(Zip)

(Phone #)

(Fax #)

Any information including the diagnosis and records of my treatment or examination rendered to me during the time period from _____ to _____.

Signature _____ **Date** _____

This authorization expires one year from the date of signature unless revoked in writing prior to expiration date. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on actions they took before they received the revocation.