7600 S Minnesota, Suite 201 Sioux Falls, SD 57108
605-271-5441 - fax: 605-271-5277
stormclinic.com

MEDICAL RECORDS RELEASE FORM

Today's Date: ________________
(this form will expire in 1 year from date)

PATIENT INFORMATION:

NAME: ______________________ DATE OF BIRTH: ____________

ADDRESS: ______________________ CITY ____________ STATE __________

ZIPCODE ____________ PHONE NUMBER ________________ CELL NUMBER ________________

NAME OF PERSON REQUESTING RECORDS:

NAME _______Dr. Jeremy Storm, DO________ RELATIONSHIP TO PATIENT: ___Infectious Disease Specialist/Internal Med___

RECORDS TO BE **SENT FROM**:

NAME: ______________________ FACILITY ______________________

ADDRESS: ______________________ CITY/STATE/ZIPCODE ______________________

PHONE NUMBER: ______________________ FAX NUMBER: ______________________

RECORDS TO BE **SENT TO**:

NAME: ______________________ FACILITY ______________________

ADDRESS: ______________________ CITY/STATE/ZIPCODE ______________________

PHONE ______________________ FAX______________________

WHAT INFORMATION IS NEEDED FOR RECORDS REQUEST. PLEASE CHECK THE APPROPRIATE BOXES

- ☐ Dictation / Notes
- ☐ Labs
- ☐ Microbiology
- ☐ Imaging Tests
- ☐ Operative Reports
- ☐ Radiology Reports
- ☐ Medication Lists
- ☐ Progress Notes
- ☐ Consult Notes
- ☐ Cultures with Sensitivites and Micro

Other: ______________________

Other: ______________________

Additional Notes from Requesting Facility: ______________________
____

Information will be disclosed because of: Transferring care ___
Referral to Specialist _____ Legal Issues _____ Patient Request _____

My Signature is approval of my authorization. I authorize the above named Physician and Medical Practice to release my protected health information to those identified on this release. I understand that if any person receives this information that is not covered by the federal privacy regulation, the release may no longer be protected. I understand that my health record may include sensitive and detaled related to STD's, AIDS, HIV, or mental health services and treatment programs.

Signature of Patient ______________________________ **Date** ______________