**Founders Park Clinic, PLLC**
**211 Founders Park Dr., Suite 3**
**Rapid City, SD 57701**
**(605)791-5959 office (605)791-5960 fax**

www.Foundersparkclinic.com
http://sendsafe.to/Foundersparkclinic@gmail.com

# Medical Record Release Authorization

**PATIENT INFORMATION**:

*Patient Full Name:_________________________________*Date of Birth:_____/_____/________

*Address:____________________________________________________________________

*City:____________________________________*State________________*Zip_____________

*Email:________________________________________*Phone Number:___________________

**AUTHORIZATION**: I authorize Founders Park Clinic, PLLC, or the Custodian of Founders Park Clinic Medical Records, to release my medical records to the following individual or entity:

*Name of Recipient:____________________________________________________________

*Address:____________________________________________________________________

*City:_____________________________________*State________________*Zip_____________

*Email:______________________*Phone Number_________________*Fax_________________

**RECORDS TO BE RELEASED**: Please specify the medical records to be released.

*All Medical Records: **Yes** _____ **No** ______ *Specific Dates ___________________

**METHOD OF RELEASE**: **Choose One.**

*Electronic Transmission (please provide **e-mail** address):______________________________

* Mail: **Yes** _____

This authorization is valid until 12/31/2024.

I understand that I have the right revoke this authorization any time by providing written notice to Founders Park Clinic, PLLC. I also understand that once my medical records are disclosed, they may no longer be protected by federal and state privacy laws.

I understand that in compliance with South Dakota statute, I may be asked to pay a fee to cover reproduction and mailing.

**Signature:**______________________________________________ **Date**:__________________
(Patient or Legal Guardian)

**Printed Name:**__________________________________________ **Date**:___________________
(Patient or Legal Guardian)