CNOS
IMPROVING HEALTH
Tel: 605-217-2667 / Fax: 605-217-2922
575 Sioux Point Road, Dakota Dunes, SD 57049
www.cnos.net

Authorization for Release of Information

PATIENT	**Name:**_____ **Date of Birth:**_____**Acct#**_____Initials_____ **Maiden or Other Name:**_____
HEALTH INFORMATION RELEASED FROM	☐ **CNOS 575 Sioux Point Road, Dakota Dunes, SD 57049** **Phone: 605-217-2667 Fax: 605-217-2900** ☐ Person/Organization:_____ Address:_____ Phone:_____ Fax:_____
HEALTH INFORMATION RELEASED TO	☐ **CNOS 575 Sioux Point Road, Dakota Dunes, SD 57049** **Phone: 605-217-2667 Fax: 605-217-2900** ☐ Person/Organization:_____ Address:_____ Phone:_____ Fax:_____
DELIVERY	☐ Fax ☐ Mail ☐ Pick up ☐Secure Email:_____
PURPOSE OF DISCLOSURE	☐ Continuity of Care ☐ Insurance ☐ Personal ☐Work Comp ☐Legal ☐ Disability/FMLA ☐ Other: _____ ☐ Follow my Health Portal Access
DATES TREATMENT TO BE RELEASED	Dates of service from (date)_____to (date)_____
HEALTH INFORMATION TO BE RELEASED	☐ **All records regarding**_____ ☐ Office Visit Notes/Progress Notes ☐ Lab Results ☐ X-Ray Reports ☐ Copy of Images ☐ MRI Reports ☐ Copy of Images ☐ Disability/FMLA ☐ Other: _____
AUTHORIZATION	1. I understand that this authorization will expire one year from date signed. 2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. It will be effective on the notification date unless action has already occurred prior to notification. 3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations. 4. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form. 5. I understand that I may see and copy the information described on this form if I ask for it. I will get a copy of this form after I sign it. 6. I understand that in compliance with South Dakota statute there may be a fee for requested records. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment. **All information regarding alcohol/drug use or abuse, mental health and/or HIV/AIDS WILL BE RELEASED unless you tell us not be by initialing below:** ____**Do not release Alcohol/Drug Use or Abuse records** ____**Do not release Mental Health records** ____**Do not release HIV/AIDS records** **X**_____ _____ Signature of Patient or Legal Representative Date If Signed by Legal Representative, Relationship to Patient: _____