Dakota Women's Clinic

625 N Foster St Ste 108
Mitchell, SD 57301
ph# 605-990-1995 fax# 605-990-1839

Patient Authorization to Release Protected Health Information

Patient Name_____Date of Birth_____

1. I hereby understand that Dakota Women's Clinic is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or healthcare operations.

2. Records To/From: **Dr. Michael Krause**
   Michele Peitz, PA-C
   625 N Foster St Ste 108
   Mitchell, SD 57301

3. Records To/From: _____
   _____
   _____
   _____

4. Type of information to be used or disclosed:_____
   Purpose for release of information:_____

5. I understand that my protected health information may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome, (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug use.

6. Name of person(s) other than named above to use and disclose my protected health information:_____

7. I understand that I have the right to revoke this authorization at any time and must do so in writing. I understand that it does not apply to information that has already been released.

8. I have read this authorization and understand what information will be used or disclosed who may use and disclose the information and the recipient of that information.

Patient Name: _____Date:_____