Setliff Sinus Institute

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Sioux Falls, SD 57103

(605) 339-1872
FAX (605) 339-3872

Medical Records Release Form

Patients Name: _____

DOB: _____

What you would like sent: (Please Circle each item to be released)

Physician Notes ***Lab Results*** ***CT Scan*** ***Operative Report***

ALL MEDICAL RECORDS (including CT Scan)

Where and how you would like them sent:

Name: _____
Address: _____
City, State, Zip: _____ _____
Mailed:_____Email_____Faxed_____Pick Up_____

Date of upcoming appointment: _____

Release to share medical information:

I, _____ authorize Setliff Sinus Institute to disclose medical information to _____ (relationship to patient:)_____.

Signature of patient or legal guardian: _____DATE:_____