Health Concepts

5410 Sheridan Lake Rd., Rapid City, SD, 57702

Richard L. Beasley, M.D. Yamuna Baral, CNP

Denise D. Carcamo, CNP

Medical Records Release

Name (printed) _____

D.O.B. _____

To: Health Concepts
5410 Sheridan Lake Rd.
Rapid City, SD 57702
Phone (605) 348-4141
Fax (605) 342-7880 Physician: _____

From: _____

(Name)

_____

(Street Address)

_____

(City) (State) (Zip)

_____

(Phone #) (Fax #)

Any information including the diagnosis and records of my treatment or examination rendered to me during the time period from _____ to _____.

Signature _____ Date _____

This authorization expires one year from the date of signature unless revoked in writing prior to expiration date. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any effect on actions they took before they received the revocation. .