STATE OF SOUTH DAKOTA
DEPARTMENT OF LABOR
DIVISION OF LABOR AND MANAGEMENT
700 Governors Drive
Pierre SD 57501

RELEASE OF MEDICAL INFORMATION

PATIENT _____
(last name) (first name) (middle)

To Whom It May Concern:

I hereby authorize you to furnish a copy of my medical records or to allow these records to be inspected or copied by a duly authorized representative of the SOUTH DAKOTA DIVISION OF LABOR AND MANAGEMENT.

I hereby release the doctor or hospital, personally, from all legal responsibility or liability that may arise from the act I have authorized above.

This release also includes receiving information from the Division of Rehabilitation Services, the Division of Retirement and Insurance, the Department of Social Services, the Social Security Administration, or other State, Federal or Private Agencies relating to disability or rehabilitation services. This is to include, but is not limited to medical, disability or rehabilitation determinations.

Date of Injury: _____ _____
(signature of patient)