Kelly McGeough Foundation

Authorization for Release of Records

Patient /Customer Name: _____

Date of Birth: _____

Account Number: _____

I authorize _____ (Provider) to disclose billing information of the above named individual/account number to Wayne Reiser (Treasurer of the Kelly McGeough Foundation).

I understand I have a right to revoke this authorization at any time. I must do so in writing to Wayne Reiser at 506 Hunters Ridge Rd., Brookings, SD 57006.

Signature of Parent or Legal Representative: _____

Date: _____

Please provide a copy of this completed form for each provider you are requesting assistance with.