



South Dakota State University

College of Agriculture and Biological Sciences
Veterinary and Biomedical Sciences Department

Animal Disease Research and Diagnostic Laboratory
Center for Infectious Disease Research and Vaccinology

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Phone: 605-688-5171; Fax: 605-688-6003

Authorization to release client information

Client Name: _____ Clinic: _____

Address: _____ City: _____ State: _____ Zip: _____

Select one: [] Single Case ADRDL Accession #: _____

[] Ongoing data transfer Date authorization ends (if applicable): _____

I hereby authorize and consent to the release of the following information:

[] Test Results [] Other (Specify): _____

[] Submission form

Individual (s) and / or entities authorized to receive client information:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

I, the undersigned, certify that I am one of the below:

[] Submitting client (veterinarian/delegate) and I have the authority to give ADRDL permission to release the client information to the individual (s) and / or entities listed above.

[] Owner of the animal(s) / farm(s) as indicated on the submission form.

By signing this form, I voluntarily agree to hold harmless and indemnify the State of South Dakota, the South Dakota Board of Regents, South Dakota State University, ADRDL their officers, agents or employees ("Releasees"), from and against any and all actions, suits, damages, liability or other proceedings that may arise as a result of its performance of this release of information to the individuals indicated above. I understand that Releasees are no longer responsible for the maintenance of confidentiality of the information after it has been released to another individual or entity. I have read and understood this agreement and release.

Signature

Date

ADRDL Use Only

[Empty space for ADRDL use]

ADRDL Authorized Signature

Date