COOK AREA HEALTH SERVICES, INC. dba
SCENIC RIVERS HEALTH SERVICES
NORTHOME
PO BOX 66
12052 MAIN STREET
NORTHOME, MN 56661
PHONE: 218/897-5222 FAX: 218/897-5226

BH

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

FIRST NAME MIDDLE NAME LAST NAME BIRTHDATE

HOME ADDRESS

PHONE NUMBERS

HOME: WORK: CELL:

THIS WILL AUTHORIZE:

NAME/ORGANIZATION: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TO RELEASE RECORDS TO:

NAME/ORGANIZATION: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

THE FOLLOWING INFORMATION IS TO BE RELEASED

☐ PSYCHOTHERAPY NOTES
☐ MENTAL HEALTH RECORDS (Specify): _____

FOR THE FOLLOWING DATE(S) OF TREATMENT OR CONDITION: _____

I AM REQUESTING THIS INFORMATION BE RELEASED FOR THE FOLLOWING PURPOSE:

☐ PATIENT REQUEST
☐ TREATMENT/CONTINUED CARE

☐ OTHER _____

*I understand I may revoke this authorization by written request at any time to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.

*This authorization will automatically expire one year from the date of my signature, or _____ (period of time, for example 2 days, or 3 weeks, or 5 months) from the date of my signature, if specified here. The expiration period noted here may exceed one year in certain situations as specified in Minnesota statue 144.335 3a; for release to a provider in connection with current treatment; for release for purposes of payment of claims, fraud investigation or quality of care; for release to an external researcher solely for purposes of medical or scientific research. As noted above, I understand I may revoke this authorization by written request at any time to the address listed above.

*I understand there may be a retrieval and copy charge associated with the release.

*I understand that once information is released pursuant to this authorization, Cook Area Health Services, Inc. cannot prevent the re-disclosure of the information to another third party.

*I understand this authorization must be filled out completely, signed, and dated in order to be considered valid. A fax or photocopy that has not been altered will be considered as valid as an original.

*I understand that I may refuse to sign this authorization and that my refusal to sign may or may not affect my ability to condition treatment, payment, enrollment, or eligibility for benefits.

_____ _____ _____

SIGNATURE OF PATIENT/AUTHORIZED PERSON AUTHORIZED PERSON'S AUTHORITY TO SIGN (PARENT, GUARDIAN, POWER OF ATTORNEY, ETC.) DATE

Copy of Power Attorney must be on Record to release/request Health Information

REASON PATIENT IS UNABLE TO SIGN: ☐ MINOR ☐ DECEASED ☐ OTHER:_____