

COOK AREA HEALTH SERVICES, INC.
dba SCENIC RIVERS HEALTH SERVICES
20 5th STREET SE
COOK, MN 55723
PHONE: 218/666-5941 FAX: 218/666-5099

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

- | | | |
|---|--|--|
| <input type="checkbox"/> DISCHARGE SUMMARY | <input type="checkbox"/> OFFICE VISITS | <input type="checkbox"/> FILMS/VIDEO/DIGITAL |
| <input type="checkbox"/> HOSPITAL OUTPATIENT/CLINIC NOTES | <input type="checkbox"/> EKG/ECHO REPORTS | <input type="checkbox"/> CARE PLANS |
| <input type="checkbox"/> HISTORY AND PHYSICAL EXAM | <input type="checkbox"/> PATHOLOGY REPORTS | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> CONSULTATION REPORTS | <input type="checkbox"/> X-RAY/RADIOLOGY REPORTS | <input type="checkbox"/> IMMUNIZATIONS |
| <input type="checkbox"/> OPERATIVE REPORTS | <input type="checkbox"/> LAB REPORTS | |
| <input type="checkbox"/> EMERGENCY SERVICES REPORTS | <input type="checkbox"/> MEDICATION LIST | |
| <input type="checkbox"/> OTHER: _____ | | |

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

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

- | | | |
|---|--|--|
| <input type="checkbox"/> PATIENT REQUEST | <input type="checkbox"/> REVIEW PATIENT'S CURRENT CARE | <input type="checkbox"/> PAYMENT |
| <input type="checkbox"/> TREATMENT/CONTINUED CARE | <input type="checkbox"/> INSURANCE CLAIM PURPOSES | <input type="checkbox"/> INSURANCE APPLICATION |
| <input type="checkbox"/> LEGAL | <input type="checkbox"/> 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 statute 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.

SIGNATURE OF PATIENT/AUTHORIZED PERSON AUTHORIZED PERSON'S AUTHORITY TO SIGN DATE

(PARENT, GUARDIAN, POWER OF ATTORNEY, ETC.)
Copy of Power Attorney must be on Record to release/request Health Information

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