

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

**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: \_\_\_\_\_