COOK AREA HEALTH SERVICES, INC. dba
SCENIC RIVERS HEALTH SERVICES
PO BOX 417
415 N 2ND STREET, SUITE 2
TOWER, MN 55790
PHONE: 218/753-2405 FAX: 218/361-3288

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

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

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
- ☐ LEGAL
- ☐ REVIEW PATIENT'S CURRENT CARE
- ☐ INSURANCE CLAIM PURPOSES
- ☐ OTHER _____
- ☐ PAYMENT
- ☐ INSURANCE APPLICATION

***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.**

_____ _____ _____

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:**_____