**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**

- ☐ 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.**

***I understand that Scenic Rivers Health Services will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign 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:**_____