COOK AREA HEALTH SERVICES, INC. dba
SCENIC RIVERS HEALTH SERVICES
239 MCKINLEY AVE
EVELETH, MN 55734
PHONE: 218/471-1800 FAX: 218/744-7908

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 that Scenic Rivers Health Services will not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization.**

***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:**_____