

SCENIC RIVERS HEALTH SERVICES
BIGFORK / BIG FALLS
PO BOX 135
135 PINE TREE DRIVE
BIGFORK, MN 56628
PHONE: 218/743-3232 FAX: 218/743-4223

SCENIC RIVERS HEALTH SERVICES
NORTHOME
12052 MAIN ST
NORTHOME, MN 56661
PHONE: 218/897-5222 FAX: 218/897-5226

Revised 08/2022

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	

DATE INFORMATION IS NEEDED BY:

*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 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: