**SCENIC RIVERS HEALTH SERVICES** 20 5th STREET SE COOK, MN 55723 PHONE: 218/666-5941 FAX: 218/666-5099

**SCENIC RIVERS HEALTH SERVICES** 415 N 2nd ST TOWER, MN 55790 PHONE: 218/753-2405 FAX: 218/361-3288

**SCENIC RIVERS HEALTH SERVICES** 239 MCKINLEY AVE EVELETH, MN 55734 PHONE: 218/471-1800 FAX: 218/744-7908

**SCENIC RIVERS HEALTH SERVICES** 810 POPLAR ST FLOODWOOD, MN 55736 PHONE: 218/476-2221 FAX: 218/476-2965

**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

HOME ADDRESS  PHONE NUMBERS  HOME: WORK: CELL:  THIS WILL AUTHORIZE:  NAME/ORGANIZATION:  STREET ADDRESS:  CITY: STATE: ZIP CODE:  TO EXCHANGE INFORMATION WITH:  NAME/ORGANIZATION:  STREET ADDRESS:  CITY: STATE: ZIP CODE:  THE FOLLOWING INFORMATION IS TO BE EXCHANGED:  IAM REQUESTING THIS INFORMATION IS TO BE EXCHANGED:  PATIENT REQUEST  PATIENT REQUEST  TREATMENTICONTINUED CARE  OTHER  I understand in 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 in apply to information that has already been released in response to this authorization.  This authorization will automatically apple one year from the date of my signature, or months) from the date of my signature, if specified here. The expiration period noted here may exceed one year incertain stantiants as specified in mineasing status (44.35 %) from these dates of the subtraction written request at any time to the address listed at the top of this form. I understand that the revocation will in apply to information that has already been released in response to this authorization.  This authorization will automatically apple one year from the date of my signature, or period noted here may exceed one year incertain stantiants as a specified in mineasing status (44.35 %) for release to a validation of the control of the	AUT	HORIZATION TO RELEA	ASE PROTECTED HEALTH IN	IFORMATION
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