

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 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.

*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 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: _____