COOK AREA HEALTH SERVICES, INC. dba
SCENIC RIVERS HEALTH SERVICES
PO BOX 66
12052 MAIN STREET
NORTHOME, MN 56661
PHONE: 218/897-5222 FAX: 218/897-5226

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
___ EKG/ECHO REPORTS
___ PATHOLOGY REPORTS
___ X-RAY/RADIOLOGY REPORTS
___ LAB REPORTS
___ MEDICATION LIST
___ CARE PLANS
___ FILMS/VIDEO/DIGITAL
___ MENTAL HEALTH
___ CARE PLANS
___ HIV/AIDS
___ OFFICE VISITS
___ 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

___ PSYCHOTHERAPY NOTES (MUST BE REQUESTED BY SEPARATE RELEASE OF INFORMATION)
___ CHEMICAL DEPENDENCY PROGRAM RECORDS

*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 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:______________________________