

Authorization to Release Protected Health Information
Crosby, Longville, Baxter, Breezy Point, Care Center and
CRMC Home Health, Palliative & Hospice Care
Phone: 218-545-4466 Fax 218-546-6091
Email: roi@cuyunamed.org

Patient Information	Name (first & last name)	Date of Birth	Phone Number
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***Patient's Email Address:**

Instructions: If any section is incomplete, this form may be invalid and could cause a delay in processing.
Release Information From (choose only one) **Release Information To (choose only one)**

<input type="checkbox"/> CRMC, 320 East Main Street, Crosby, MN 56441 <input type="checkbox"/> Other (specify facility/individual & address below, including phone / fax if known) _____ _____ _____	<input type="checkbox"/> CRMC, 320 East Main Street, Crosby, MN 56441 <input type="checkbox"/> Other (specify facility/individual & address below, including phone / fax if known) _____ _____ _____
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Purpose for Release

<input type="checkbox"/> Continued Care	<input type="checkbox"/> Work Comp	<input type="checkbox"/> Personal	<input type="checkbox"/> Legal Purposes
<input type="checkbox"/> Application of Insurance	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Payment of insurance claim	
<input type="checkbox"/> Other (details) _____			

Information To Be Released

****Required - check all that apply**
Send all Routine Records (in date range specified below)
 Provider Notes, Lab, Radiology, Procedures, Test Results.
Or Send Other Records

<input type="checkbox"/> Medication List	<input type="checkbox"/> History & Physical	<input type="checkbox"/> Provider Notes	<input type="checkbox"/> Emergency Report
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Care Center Notes	<input type="checkbox"/> Rehab Records (PT,OT,SP)	<input type="checkbox"/> Lab Reports
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> EKG's	<input type="checkbox"/> Operative/Procedure Reports	<input type="checkbox"/> HIV/Aids Testing
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Radiology Imaging	<input type="checkbox"/> Billing Information	<input type="checkbox"/> Workability Form
<input type="checkbox"/> Other (specify contents and dates) _____			

*All information regarding alcohol and/or drug abuse, behavioral health and psychotherapy will be released **unless you restrict** by initialing below:
 _____ Do not release alcohol and/or drug abuse information _____ Do not release behavioral health information
 _____ Do not release Psychotherapy Records

Dates of Service: (1 year will be sent if nothing specified) From: _____ To: _____	Information needed by: ____/____/____
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Release Method / Format

For Copies: Paper MyChart *Electronic Delivery (to patient only, complete email address above)
 Faxed _____ (fax number) Pick up (Photo ID required)

This authorization will expire one year from the date of signing unless I indicate and earlier date here: ____/____/____
 The authorization may be revoked at any time except to the extent that action has previously been taken. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. **I may be charged for copies in accordance with state law.** Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal law. Copy is as good as an original.

Patient Signature and Date are required to release records. If an Authorized Person is signing you must include legal documentation.	Patient Signature _____ Date _____	Signature of Authorized Person _____ Date _____ Print Authorized Person's Name _____ <input type="checkbox"/> *Parent of Minor <input type="checkbox"/> Court appointed guardian/conservator <input type="checkbox"/> Healthcare Agent / POA
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