CRMC
CUYUNA REGIONAL MEDICAL CENTER
Dedicated to You. Every Day.

☐ **HOSPITAL SERVICES** ☐ **CLINIC SERVICES**
☐ **HOMEHEALTH PARTNERSHIP**
Crosby, Baxter, Longville
Phone # 218-545-4466 Fax #: 218-546-6091

AUTHORIZATION for the USE, DISCLOSURE or RELEASE of CONFIDENTIAL INFORMATION

Please use legal name (no nicknames). Please list all other last names as applicable.

Delivery Format: ***(option only pertains when releasing directly to the patient)***
☐ **Paper** ☐ **Electronic Delivery –** *Additional form must be completed, please request "Electronic Record Delivery Request" form*

***Facility Names/ Address and Phone Numbers Are Required**

SEND RECORDS FROM: SEND RECORDS TO:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Name/Alias: _____
Address: _____
City/St/Zip: _____
Phone #: _____
DOB: _____

Dates of treatment and/or specific illness/injury: _____

☐ Discharge Summary ☐ ER Reports ☐ Clinic Progress Note(s)
☐ Consultation Report(s) ☐ X-ray Report(s) / CD(s) [Circle one or both] ☐ Physical Therapy
☐ Pathology Report(s) ☐ Operative Report(s) ☐ Care Center
☐ EKG/EEG Report(s) ☐ History & Physical ☐ Hospital Progress Note(s)
☐ Bills and/or Statements ☐ Lab Report(s) ☐ Medication List
☐ Problem List ☐ Home Care
☐ Other (specify): _____

This information is needed for the following purpose(s):
☐ Insurance Claim(s) ☐ Litigation ☐ Workman Compensation
☐ Personal Use ☐ Continuing Care_____ ☐ Other _____
(Facility Name) **(Details Please)**

With the exception of psychotherapy notes, all chemical dependency treatment records, psychiatric records, sickle cell anemia records, and/ or records relating to communicable diseases such as HIV, AIDS and sexually transmitted diseases **will be** released unless otherwise indicated by initialing here: _____ initials of the patient.

*****A 2 year medical history will be sent for all Continued Care or Personal Use request, unless shorter time is specified.***

I understand that if the person or entity that receives the information is not covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. I do not authorize further release to any third party and herby release the hospital, clinic, their employees and my physician(s) from any and all liability arising directly or indirectly from such re-disclosure.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used or disclosed under this authorization.

I understand that I may revoke this authorization at any time before my records are released by mailing or presenting the written request in person to the health information department.

☐ I give permission for records created after my signature date to be disclosed.
Unless otherwise revoked, this authorization will automatically expire in one year unless an event or different date is specified here ____/____/____. A copy of this authorization is as good as an original.

_____ _____/_____/_____
Signature of patient or legal representative Date

_____**Parent***(pt is a minor)* _____***Guardian** _____***POA of HealthCare** _____***Executor or Personal Representative of deceased patient**
***If signing as a representative of the patient, please make sure you have supplied the proper legal papers.**

ID of requestor verified? ☐ Method:_____ Who verified?_____ ☐ Date Records needed_____

☐ Records have been sent_____ ☐ Records have not been sent_____ ☐ Patient to pick up records on_____ ☐ Faxed_____

ROIF

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