



CUYUNA REGIONAL MEDICAL CENTER

Dedicated to You. Every Day.

AUTHORIZATION for the USE, DISCLOSURE or RELEASE of CONFIDENTIAL INFORMATION

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

HOSPITAL SERVICES CLINIC SERVICES OR BOTH

Fax #: 218-546-6091

Fax #: 218-546-4400

SEND RECORDS FROM:

SEND RECORDS TO:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
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\_\_\_\_\_

Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/St/Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
DOB/MR#: \_\_\_\_\_  
SSN: \_\_\_\_\_

Dates of treatment and/or specific illness/injury: \_\_\_\_\_

- Discharge Summary ER Reports Progress Note(s)
Consultation Report(s) X-ray Report(s) / CD(s) [Circle on or both]
Pathology Report(s) Operative Report(s)
EKG/EEG Report(s) History & Physical
Bills and/or Statements Lab Report(s)
Other (specify): \_\_\_\_\_

This information is needed for the following purpose(s):

- Insurance Claim(s) Litigation Workman Compensation
Personal Use Continuing Care Other \_\_\_\_\_ (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.

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 hereby 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.

Unless otherwise revoked, this authorization will automatically expire once the above-stated purpose is fulfilled. A copy of this authorization is as good as an original. Records will be sent only up to the date of the signature.

Signature of patient or legal representative Date

\* Parent Guardian POA of HealthCare Executor or Personal Representative of deceased patient

ID of requestor verified? Method: Who verified?

- Records have been sent Records have not been sent Patient to pick up records on Faxed
Date Records needed

\*ROIF\*