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

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

Patient Information	Name (first & last name)	Date of Birth	Phone Number
***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	**Release Information To**
☐ CRMC, 320 East Main Street, Crosby, MN 56441 ☐ Other (specify facility/individual & address below, including phone / fax if known) __________ __________ __________ __________	☐ CRMC, 320 East Main Street, Crosby, MN 56441 ☐ Other (specify facility/individual & address below, including phone / fax if known) __________ __________ __________ __________

Purpose for Release

☐ Continued Care ☐ Work Comp ☐ Personal ☐ Legal Purposes
☐ Application of Insurance ☐ Disability Determination ☐ Payment of insurance claim
☐ Other (details) ____

Information To Be Released

*****Required - check all that apply***

Send all Routine Records

☐ Provider Notes, Lab, Radiology, Procedures, Test Results.

Or Send Other Records

☐ Medication List ☐ History & Physical ☐ Provider Notes ☐ Emergency Report
☐ Discharge Summary ☐ Care Center Notes ☐ Rehab Records (PT,OT,SP) ☐ Lab Reports
☐ Pathology Reports ☐ EKG's ☐ Operative/Procedure Reports ☐ HIV/Aids Testing
☐ Radiology Reports ☐ Radiology Imaging ☐ Billing Information ☐ Workability Form
☐ 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: From:__________________ To: __________________	Information needed by: (optional) ☐ Records Sent _______ (initial)

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

Release Method / Format

For Copies: ☐ Paper ☐ MyChart ☐ *Electronic Delivery (to patient only, complete email address above)
☐ Pick up (Photo ID required) For Imaging / MRI: ☐ CD

This authorization will expire one year from the date of signing unless I indicate and earlier date or event 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. ☐ **I give permission to also include records created after my signature date.**

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 ☐ *Parent of Minor ☐ Court appointed guardian/conservator ☐ Healthcare Agent / POA