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

☐ **HOSPITAL SERVICES** ☐ **CLINIC SERVICES** ☐ **OR BOTH**
Crosby, Baxter, Longville
Phone # 218-546-4343 Fax #: 218-546-4646

AUTHORIZATION for the USE, DISCLOSURE or RELEASE of CONFIDENTIAL INFORMATION
Please use legal name (no nicknames). Please list all other last names as applicable.

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

SEND RECORDS FROM:

_____
_____
_____
_____
_____
_____

SEND RECORDS TO:
Cuyuna Regional Medical Center
ATTN: MIMIS/Bariatric Department
320 East Main Street
Crosby, MN 56441
Fax: 218-546-4646

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

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

X Discharge Summary
X Consultation Report(s)
X Pathology Report(s)
X EKG/EEG Report(s)
X Nutritional/Dietary Consults
X ER Reports
X X-ray Report(s) / CD(s) [Circle one or both]
X Operative Report(s)
X History & Physical
X Lab Report(s)
X Clinic Progress Note(s)
X Physical Therapy
X Medication List
XOther (specify): _____

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

X Continuing Care_Cuyuna Regional Medical Center ☐ 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.

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?_____

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

ROI

Rev 06/23/2020