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
Email: roi@cuyunamed.org

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 (choose only one)	**Release Information To (choose only one)**
☐ 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 (in date range specified below)
☐ 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: (1 year will be sent if nothing specified)	
From:_____ **To:** _____	Information needed by: _____/_____/_____

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

Created: 12/7/2017 Updated: 4/25/2022

Staff Initials if records have already been sent: _____