FOR INTERNAL USE ONLY:

MR# _____
Pick Up Date: _____
□ Records have been mailed/Picked up
□ Records have been faxed.
FAX#: _____
□ Records have not been sent.
Reason: _____
Initials: _____ Date: _____

CMH Community Memorial Hospital

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. PATIENT IDENTIFICATION INFORMATION:

PATIENT NAME:		DATE OF BIRTH:	
ADDRESS:	CITY	STATE	ZIP
PHONE NUMBER: Home:_____ Other: _____		PREVIOUS NAME(S):	

2. RELEASE INFORMATION FROM

☐ Community Memorial Hospital
512 Skyline Blvd
Cloquet, MN 55720
Fax: 218-879-3237

☐ CMH Raiter Family Clinic
417 Skyline Blvd
Cloquet, MN 55720
Fax: 218-879-8904

☐ Other (Specify facility/dept/individual & address below, including phone/fax if known.)

_____
_____
_____

3. RELEASE INFORMATION TO

☐ Community Memorial Hospital
Attn: _____
512 Skyline Blvd.
Cloquet, MN 55720
Phone: 218-878-7023 Fax: 218-879-3237

☐ Other (Specify facility/dept/individual & address below, including phone/fax if known.)

_____
_____
_____

4. RECORDS TO BE RELEASED

Service Dates
From: **To:**

Date Information Needed By:

□ Lab Reports □ Pathology Reports □ Consultation Notes □ Physician Office Notes
□ History & Physical □ Emergency Service Reports □ Physical Therapy □ Billing and/or statements
□ Discharge Summary □ Imaging (X-ray) Reports □ Occupational Therapy □ Wound Clinic/Photos
□ Operative Reports □ Imaging (X-ray) Film □ Speech Therapy □ Other: _____

5. PURPOSE OF RELEASE

□ Continued Care □ Insurance □ Litigation/Legal
□ Personal Use □ Work Comp □ Other (specify):_____

6. I understand I may revoke this authorization by written request to the Health Information Department of the releasing facility. I understand that the revocation will not apply to information that has already been released in response to this authorization. Upon fulfillment of the above stated purposes, this authorization will automatically expire one year from the date of my signature. I understand that all records pertaining to psychiatric/mental health, chemical dependency, and/or AIDS/HIV related illness/testing will be released unless indicated by initialing here: _____.
Please specify any restrictions:_____.
I understand that once information is released pursuant to this authorization, re-disclosure of the information by the recipient cannot be prevented. I understand that I may be charged for copies in accordance with state law. I understand authorizing the release of this information is voluntary. I need not sign this authorization to receive healthcare treatment.

7. ☐ **I authorize the release of medical information specified above that is created after the date of my signature for one (1) year.**

8. ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

- **If the patient is 18 years of age or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older, and is incapable of signing,** a legally authorized substitute may sign the form.

Please indicate your legal authority and include documentation of your relationship: ☐ **Legal Guardian or Conservator** ☐ **Health Care Agent**

- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship. **By signing, I hereby state that my parental rights have not been revoked by a court of law.** ☐ **Parent** ☐ **Legal Guardian**

Signature: (*Required)* **Date Signed:** (*Required, mm/dd/yyyy)*

Printed Name of Person Signing *(if not patient)*

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CMH Community Memorial Hospital

AUTHORIZATION COMPLETION INSTRUCTIONS

To protect the privacy of our patients and to maintain the confidentiality of their personal health information, we must obtain a valid, complete and legible authorization for release of medical records.

1. **Patient**
   - Name: *Print the full, legal name of the patient*
   - Date of Birth: *Month, Day and Year of birth*
   - Address: *Street address, City, State and Zip of patient*
   - Phone: *Patient's phone numbers*
2. **Release Information From**
   - Check the sites listed where you have received care and would like your records released from.
   - If the provider authorized to release medical records is other than a Community Memorial Hospital facility, check the Other box and complete the individual, Facility or Company Name of the person or provider. Fill in their complete address. Include phone and/or fax number if known.
3. **Release Information To**
   - Print the name of the person or organization that is to receive the medical records along with their complete address, city, state, and zip code. Please include their phone and/or fax number if known or check the box to release to Community Memorial Hospital.
4. **Records to be Released**
   - Fill in the approximate dates of service if known.
   - If records are needed by a specific date, fill in the Date Information Needed By.
   - Check the box next to the types of medical records requested.
   - If the Other box is check, please write the needed medical records in the space provided.
   - If requester wants records specific to an injury, illness or treatment, use the Other box.
5. **Purpose of Release**
   - Check the appropriate box that best explains the purpose of the request.
   - If the Other box is checked, please write the reason in the space provided.
6. **Expiration Date**
   - This authorization will remain valid for one year after the date of signature.
   - During this timeframe, only the records indicated on this request are authorized. To request new/different records, a new authorization needs to be completed.
7. **I extend to release any or all documents in the upcoming year:**
   - Check this box to authorize medical records that are created after the date of signature on this form to be released. If this box is not checked, we are only able to release medical records that were created on or before the date this authorization was signed.
8. **Signature:**
   - The patient or legal representative must sign and date the authorization.
   - Attach copies of legal documents outlining the representative's legal right to sign on the patient's behalf.

Return your completed authorization to the Release of Information Department.

Community Memorial Hospital
Attn: HIS
512 Skyline Blvd
Cloquet, MN 55720
Phone: 218-878-7023
Fax: 218-879-3237

CMH Raiter Clinic
Attn: HIS
417 Skyline Blvd
Cloquet, MN 55720
Phone: 218-879-1271
Fax: 218-879-8904