

MR# _____
 CMH Completed - Date: _____
 RC Completed - Date: _____
 Not sent - reason: _____
 Initials: _____ Date: _____

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 Association
*Includes: Hospital/Specialty Clinic, Sunnyside Health Care Center, CMH Raiter Family Medicine Clinic

Other (Specify facility/dept/individual & additional info. below)
 Name: _____
 Address: _____
 City/State/Zip: _____
 Phone: _____
 Fax: _____

3. RELEASE INFORMATION TO

Community Memorial Hospital Association
 Attn: _____

Other (Specify facility/dept/individual & additional info. below)
 Name: _____
 Address: _____
 City/State/Zip: _____
 Phone: _____
 Fax: _____

4. RECORDS TO BE RELEASED

History & Physical Medications Care Plan Radiology Reports
 Lab/Pathology Reports Photographs Immunizations Radiology Images (not able to fax images)
 Emergency Room Report Discharge Summary Consultation Reports Therapy Reports (PT/OT/ST/CR/PR)
 Surgery Report Progress/Office Visit Notes Cardiac/EKG Reports
 Other (MUST SPECIFY. 'ALL RECORDS' will not be accepted): _____

Service Dates From: _____ To: _____ **Information Needed By:** (Date): _____

5. PURPOSE OF RELEASE

Personal Use Insurance Worker's Comp. Litigation/Legal/Attorney Disability/Social Security
 Continued Care - Appt Date: _____ Other (Specify): _____

6. DELIVERY METHOD

Mail Pick up by patient/authorized designee (requires photo ID)
 Fax to: _____ Review of Record (no copies)
 Email to: _____

NOTE: There may be a charge/fee for copies of records.

7. All information regarding alcohol/drug use or abuse, mental health and/or HIV/AIDS/STD WILL BE RELEASED unless you tell us NOT to by initialing below:

Do not release Alcohol/Drug Use or Abuse records Do not release Mental Health records Do not release HIV/AIDS/STD records

This authorization will terminate in one year unless otherwise specified: _____

I understand that I may stop this release at any time by writing to the HIS department. Once the health information has been released to another facility or provider, there is no way to cancel or stop the release. I understand that when the health information is released the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that CMH will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. I understand that I must sign this form to release my health information.

NOTE: An adult patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. Legal documentation of the right of access by the signing individual may be required.

A photocopy of this authorization is as valid as the original.

Signature of patient or authorized representative: (Required) _____ **Date Signed:** (Required, mm/dd/yyyy) _____

Printed Name of authorized representative (if not patient) _____ Relationship (if not patient) _____

Instructions for Completing the Authorization to Release Protected Health Information

1. Patient Information - print the patient's:
 - Full legal name
 - Maiden name or any alias names used
 - Date of Birth
 - Phone Number
2. Health Information Released FROM: Check only one of the boxes. If choosing "Other" please provide the organization's name and address from which to obtain information.
3. Health Information Released TO: Print the name of the person or organization that is to receive the information. Be sure to include the complete address, city and state and/or fax number.
4. Health Information to be Released: Indicate a date of service, type of visit (clinic, inpatient, radiology, etc.) or specific report types as listed on the form.
All sensitive information, including alcohol and drug use/abuse records, mental health records and HIV/AIDS records will be released unless the individual items are initialed. Initial each line indicating the specific sensitive information you DO NOT want us to release.
5. Form or format of release:
 - Hard Copies – check this box if you are allowing paper copies of your information to be given to the party listed in #3. Be sure to indicate what information should be release in the Health Information to be Released section. If only allowing release of records relating to specific illness/injury, please list it on the Other line.
 - Electronic – check this box if you are looking to have your information sent to party listed in #3 via an electronic form such as a CD or email. Please remember that if you need these records faxed you cannot choose this option. Also note that the recipient of the electronic release will need to have computer applications that allow them to view a PDF file.
Please note: Emailing patient information in an unencrypted email is a risk to your private health information. Email accounts can be compromised or emails in transit can be intercepted. By choosing a release via email, you recognize and accept this risk.
 - Verbal Exchange – Check this box if you are allowing verbal discussions of your health and billing information with parties listed.
 - Review of Record – check this box if you are allowing the review of your medical record by the party listed in #3 above.
6. Purpose of Release: Check appropriate box or write in if other purpose. If you have an upcoming appointment that these records are needed for, please provide the appointment date.
7. Delivery Method: Please check the box to indicate how the records should be sent to the party in #3.
 - Mail or Email – if you check this box, please make sure you have a complete address for the party in #3.
 - Fax – check this box for continued care release only and be sure to include a fax number for the party in #3.
 - Pickup by patient/designee – check this box if you want to have the information picked up. Whomever you would like to pick up the information will need to be listed as the party in #3. The person picking up the information will need to have a valid photo identification card.
8. Authorization/Revocation: This authorization will terminate one year from the date signed unless you specify an earlier date. Any medical information after the date of signature will not be released. If you need to have your information sent after the date signed on this form, please ask the staff for help. The patient or legal representative must sign and date the authorization for it to be valid. If a legal representative sign we will need a copy of a document showing legal representation.
9. There may be a charge for records.

If help is needed to complete this form, you may contact the CMH HIS Release of Information staff at 218-878-7023, CMH Raiter HIS Release of information staff at 218-879-1271 or stop by the Medical Records office at the times listed below:

- Monday - 8:00 AM – 4:30 PM
- Tuesday - Friday, 8:00 AM – 4:00 PM
- Closed Saturdays, Sundays and Major Holidays