1. **Patient** Information	**PATIENT NAME**_____ Date of Birth _____ Day phone_____ Email _____
2. Health Care Provider or Clinic/Hospital **who has the information** you want released?	☐ **COMMUNITY MEMORIAL HOSPITAL ASSOCIATION** ☐ **Include CMH Raiter Clinic records?** **OR** ☐ **NAME/ORGANIZATION**_____ Phone_____ Address_____ Fax _____ City_____ State_____ Zip _____
3. **Where** do you want the information to be sent?	☐ **COMMUNITY MEMORIAL HOSPITAL ASSOCIATION** **OR** ☐ **NAME/ORGANIZATION**_____ Phone_____ Address_____ Fax _____ City_____ State_____ Zip_____
4. **Why** is it needed?	☐ Continuing Care ☐ Insurance ☐ Legal ☐ Worker's Compensation ☐ Personal Use ☐ Social Security/Disability ☐ School ☐ Other: _____
5. **What are the approximate dates** of information you want released? **What** do you want released? Choose **Routine** for items a health care provider typically needs or select individual records.	**SERVICE DATES BETWEEN**_____ **to** _____ ☐ **Send all Routine Records** (Notes, History & Physical, Discharge Summaries, Emergency Room, Lab, Radiology, Procedures, Test Results, and Consultations) **OR send these other records:** ☐ Discharge Summary ☐ Progress/Provider Notes ☐ Lab/Pathology reports ☐ History & Physical ☐ Consultation Reports ☐ Radiology Reports ☐ Operative/Procedure Reports ☐ Emergency Reports ☐ Radiology Images (NOT FAXED) ☐ Therapy Reports (PT/OT/SP/CR/PR) ☐ Care Plan ☐ Cardiac/EKG Reports ☐ Medication List ☐ Immunization records ☐ Other (must specify): _____ All sensitive information (including alcohol and/or drug use or abuse, mental health, and/or HIV/AIDS/STD testing) **WILL BE RELEASED *unless* you restrict us by initialing below:** ____ Do not release alcohol/drug records_____ Do not release mental health records____ Do not release HIV/AIDS/STD records
6. **When** is it needed?	**Date the information is needed:**____/____/____ **OR date of the appointment:**____/____/____
7. **How** do you want the information?	☐ Pick up by patient/authorized designee ☐ Mail ☐ Review of record (no copies) ☐ Fax to:_____ ☐ Email to: _____ **NOTE:** By signing below I acknowledge that there may be a charge/fee for copies of records.

- This authorization lasts for one year after the date you sign it unless otherwise specified here: _____
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance on it.
- I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand that CMH will not condition my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- I understand, upon request, I will receive a copy of this form after I have signed it.
- I understand a photocopy or fax of this form is the same as the original.

8. **Patient Signature** and **Date** are required to release records. If an **Authorized Person** is signing you must include **legal documentation**.	_____ _____ *Patient/Representative Signature* *Date* _____ _____ *Printed name (if not patient)* *Relationship to patient*

CMH Community Memorial Hospital

Health Information Management – Release of Information, 512 Skyline Blvd.
Cloquet MN 55720 | Phone: 218-878-7023 | Fax: 218-879-3237

FOR INTERNAL USE ONLY:
MR#_____ Staff initials: _____
□CMH Completed - Date: _____
□RC Completed - Date: _____
□Not sent - reason: _____