COOK® CLINIC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: _____ **SS#:** _____

STREET ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: ( ) _____ **DATE OF BIRTH:** _____

The undersigned hereby authorizes **COOK® Family Health Center** , of **Bloomington, IN**, to release the following portions of the medical records of the above named patient:

_____ Entire medical record for period of _____ to _____

_____ The following specific portions of the medical record: _____

_____ for the period of _____ to _____

Release this information to:

_____

(Name of person or institution)

_____

(Street address, City, State & Zip Code of person or institution)

The medical record is needed for the following purpose:

_____

(State general purpose or intended use of the medical record)

I, the undersigned, understand that I may *REVOKE* this authorization at any time, in writing, but the request shall remain valid until revoked or upon the expiration of sixty (60) days, whichever occurs first, *EXCEPT* to the extent that action has been taken thereon. I understand that I am giving permission to release federally protected medical information which may include treatment for physical and/or emotional illness, communicable diseases, alcohol or drug abuse treatment, and/or HIV, AIDS, or AIDS-related information. A copy shall be considered as valid as the original. (Charges may apply for copying records.)

_____ _____

*Signature (as designated by law) Date of Signature

_____ _____

Relationship (if other than patient) Witness

Released by: _____ Date: _____

402 North Rogers Street Bloomington, IN 47403 Phone: 812-330-9944 Fax: 812-330-1933