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 _____, of _____,
(Name of facility/practicioner) *(Mailing address)*
_____, 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:

COOK® Family Health Center, ATTN: Medical Records
402 North Rogers Street, Bloomington, IN 47404-3740

The medical record is needed for the following purpose:

New Primary Care Physician due to change in insurance coverage

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: _____