COOK® CLINIC

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

Street Address: _____

City, State, ZIP Code: _____

Telephone Number: (____)_____ **Date of Birth:** _____

Please forward copies of requested records from:

Name: _____

Address: _____

City, State, ZIP code: _____

Phone: _____

Fax: _____

☐ Entire medical record

☐ Specific dates of treatment: From _____ to _____

☐ Other: _____

The medical record is needed for the following purpose:

New Primary Care Physician due to change in insurance coverage

Release this information to:

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

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 six (6) months, 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.)

The Cook Family Health Center cannot prevent redisclosure of your medical information by the entity in which received your records under this authorization. State and Federal privacy protections may not cover your medical information after it is released. By signing this authorization, you release the Cook Family Health Center from all liability resulting from redisclosure.

Patient Signature: _____ Date: _____

Parent/Legal Representative: _____ Date: _____