Authorization for Release of Information

402 N Rogers Street Bloomington, Indiana 47404
Phone: (812) 330-9944 Fax: (812) 330-1933

Patient Name: _____ Date of Birth: _____ Address: _____ _____ City, State, Zip: _____ Phone Number: _____	I authorize the Cook Family Health Center to: ☐ **release** ☐ **request** my medical records to/from: Name of person/organization: _____ Address (number and street, city, state, ZIP code) _____ _____ Phone Number: _____ Fax Number: _____

The medical record is needed for the following purpose:

☐ Transfer of care (last 1-2 years, per outside providers)

☐ Continuation of care (records specific to specialist's needs)

☐ Legal Purpose (specific dates from _____ to _____)

☐ Personal Use (specific dates from _____ to _____)

☐ Other _____

Failure to provide complete and accurate information may delay or prohibit the processing of your request.

Patient requests for copies of entire medical records will only include the previous 7 years, per Indiana law.

Description of information to be released:

☐ All Records		
☐ Office Visit Notes	☐ Lab Results/Reports	☐ Imaging/X-Ray Reports
☐ Consultation Reports	☐ Procedure Reports	☐ Operative/Pathology Reports
☐ Billing Records	☐ Other _____	

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 have been taken thereon. I understand that I am giving permission to release federally protected medical information which may include, but not limited to, treatment for physical and/or emotional illness, communicable diseases, psychotherapy notes, genetic testing, sexual assault or child abuse/neglect, 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: _____

Legal Representative: _____ Date: _____

Witnessed By: _____ Date: _____

Released By: _____ Date: _____