

Cook Hospital and C&NC Unit
Authorization for Release of Medical Information

This will authorize release of records from:

PATIENT IDENTIFICATION INFORMATION:

Name: _____ **Date of Birth:** _____

Address: _____

Phone Numbers: (H) _____ (W) _____ Other _____

RECORDS TO BE RELEASED: (Please note that records can not be released until they are complete. Dictated reports are not official until they are signed by the physician.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Physician Notes | <input type="checkbox"/> Bills and/or Statements |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> X-ray Films | <input type="checkbox"/> Emergency Record |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> X-ray Reports | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Operation Reports | <input type="checkbox"/> Diagnostic Test Reports | <input type="checkbox"/> Other _____ |

for the following medical condition or injury:

occurring on or about:

_____ (date)

PURPOSE OF RELEASE:

Continued Care Insurance Legal Self Other (specify) _____

RELEASE TO (The information specified above will be released to):

NAME: _____ **PHONE #** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

TO THE PATIENT:

I understand that I may revoke this authorization (in writing to the Health Information Department of the releasing facility) at any time and that upon fulfillment of the above-stated purpose(s), this consent will expire twelve months from the date of signature only to the person or company indicated above. I understand that the revocation will not apply to any information that has already been released in response to this authorization.

A photocopy of this authorization will be treated in the same manner as the original.

I understand that once information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

I understand that all records pertaining to psychiatric/mental health, chemical dependency and/or AIDS/HIV related illness will be released unless otherwise indicated by initialing here: _____ Specify restrictions _____

I understand authorizing the use or disclosure of information is voluntary. I need not sign this authorization to receive healthcare treatment.

Patient or Guardian Signature _____ **Date** _____

If signing as the authorized representative of the patient, I am: (please check one)

the court appointed guardian or conservator of the patient (Legal Documentation Required)

a custodial parent of a minor

other, explain _____

Signature of Witness _____

