Cook Hospital & Care Center
AUTHORIZATION FOR
RELEASE OF MEDICAL INFORMATION

This will authorize release of records from the COOK HOSPITAL, 10 FIFTH STREET SE, COOK, MN 55723
OR FROM:_____

PATIENT IDENTIFICATION INFORMATION

First Name:_____Last Name:_____Date of Birth:_____/_____/_____

Street Address:_____ City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Other Phone:_____

RECORDS TO BE RELEASED

Check all that apply:

____Lab Reports	____Physician Notes	____Bills and/or Statements
____History & Physical	____X-ray Films	____Emergency Record
____Discharge Summary	____X-ray Reports	____Consultation Report
____Operation Reports	____Diagnostic Test Reports	____Other:_____

for the following medical condition or injury:_____

occurring on or about (date):_____

Purpose of Release – check all that apply:

____Continued Care ____Insurance ____Legal ____Self ____Other:_____

(NOTE: Records cannot be released until they are completed. Dictated reports are not official until they are signed by the physician.)

RELEASE RECORDS TO

The information specified above will be released to:

Name:_____ Phone:_____ Fax:_____

Address:_____ City:_____State:_____Zip:_____

TO THE PATIENT

I understand that I may revoke this authorization at any time (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 of disclosure of information is voluntary. I need not sign this authorization to receive healthcare treatment.

***Patient/Guardian Signature**:_____**Date:**_____*

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

____the court appointed guardian or conservator of the patient – legal documentation is required
____a custodial parent of a minor
____other, explain:_____

Witness Signature:_____