AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that my/my child"s medical records are confidential and cannot be disclosed without my written authorization except otherwise provided for by law. I hereby voluntarily authorize Cook Children's Physician Network to release following information from the medical record of:

____ ________________
(Patient Name) (Birth Date)

The information specified below may be released to:

Name: ____

Address: ____

City: ____State: _____________ Zip Code: ___________ Telephone ______________

The specific purpose(s) for this disclosure is/are:
[ ] My personal use [ ] sharing with other healthcare providers
[ ] other (please describe) ____

[ ] I WANT [ ] I DO NOT WANT (please check one) you to include information pertaining to the diagnosis and treatment of HIV testing, AIDS, psychiatric illness, and alcohol and/or chemical abuse and dependency if any.

SPECIFIC INFORMATION TO BE RELEASED: (please check all that you are requesting be released)
[ ] Complete Medial Record for this Office [ ] Immunization Records Only
[ ] History & Physical [ ] Diagnostic Testing & Results
[ ] Other (Please List)

- I understand that I may revoke this authorization at any time y notifying the office in writing at ATTN: Practice Manager. Medical Record Request of m intent to revoke this authorization, and that such revocation will not have any effect on any actions taken by the office before the revocation.
- I understand this authorization expires 180 days from the date signed, unless otherwise revokedor noted: This consent is hereby extended for 1 yeaar: Initials: _______ Witnessed by ______________________.
- I understand that once the above 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 I may be asked to show proof that I have the authority to sign an authorization to review and/or receive copies of the above named medical record which I am requesting.
- I understand that I may be charged for copies of my/my child's medical record, which I request for myself or for the use by others. I also understand copies are due and payable before copies are released.
- I understand that photocopy or facsimile of this authorization is as valid as the original.

______________ ____
Date Signature of Patient, Parent or. Legally Authorized Representative Guardian

_______________________________________ ____________________________________
Print Name Relationship to Patient