CENTER FOR FOOT AND ANKLE RESTORATION
CHARLES E. COOK, MD
8440 Walnut Hill Ln #110
Dallas, Texas 75231
214-265-7175

Medical Records Release Form

I, _____ ____/____/____ _____
(Patient Name) (Birth date) (Social Security Number)
hereby authorize Charles Cook, MD to disclose the following medical information, by ____Mail or ____Fax, to:

Name _____
Address _____
_____
_____

Phone Number _____ Fax Number _____

The specific information to be released:
☐ Complete Records ☐ Operative reports Only ☐ Other _____
☐ Office visits Only ☐ History & Physical Only
☐ X-rays Only ☐ Laboratory/ Testing Reports ordered by Dr. Cook

Records requested pertain specifically to my medical treatment date(s) of _____. This information is to be used for the specific purpose of:
☐ Second Opinion ☐ Disability Determination ☐ Attorney / Legal purposes
☐ Insurance Company ☐ Personal Use ☐ Other (specify) _____

I understand that the specific information to be released may include, but is not limited to, drug related conditions, the treatment of drug or alcohol abuse, alcoholism, mental illness, or communicable disease, including HIV and AIDS or infectious diseases. I also understand that any disclosure is bound by Title 42 of the code of Federal Regulations governing the confidentiality of alcohol and drug abuse and or psychiatric treatment of patient records and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

☐ I consent for this information to be released ☐ I do NOT consent for this information to be released

I, the undersigned, have read the above and authorize the staff of Dr. Cook's office to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This facility is released and discharged of any liability, and the undersigned will hold the facility harmless, for complying with this "Authorization for Release of Medical Information". In the absence of my prior revocation, this authorization expires **ninety days** from the date below.

Dr. Cook may charge an administrative fee for processing records. If such is the case, I will be informed by the Custodian of Medical Records, payment will be requested in advance, and seven to ten working days should be allowed for processing the records. *Fees/Charges will comply with all laws and regulations applicable to release of information.* I understand that a photocopy of this authorization is as valid as the original.

Signature: _____ Date: ____/____/____ Relationship to Patient: _____

Printed Name: _____ Witness: _____ Date: ____/____/____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records that are confidential. You are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

REVOCATION:
I hereby revoke the consent given above.
Signature: _____ Date: ____/____/____ Relationship to Patient: _____

Printed Name: _____ Witness: _____ Date: ____/____/____