CENTER FOR FOOT AND ANKLE RESTORATION

A Division of Orthopedic Specialists

Charles E. Cook, MD
Certified, American Board of Orthopaedic Surgery

John M. Noack, MD
Board Eligible, American Board of Orthopaedic Surgery

MEDICAL RECORDS RELEASE FORM

I,_____ ___/___/___ _____

(Patient Name) (Birth Date) (Social Security Number)

Hereby authorize the release of medical records from:

Name_____| Phone_____

Address_____| Fax_____

_____|

_____|

To be sent by Mail_____ or Fax_____ to the following:

CENTER FOR FOOT AND ANKLE RESTORATION
Charles E. Cook, M.D.// John M. Noack, M.D.
8440 Walnut Hill Ln., Ste. 110
Dallas, TX 75231
Phone: 214-265-7175
Fax: 214-691-5940

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

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

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