Cooper Family Medical

Request for protected health information/ patient authorization for release of records

Patient name _____ Date of birth _____

Requested dates: □ Last 2 years

Request information from this practice/facility: Cooper Family Medical

Release information to:
_____
_____
_____

Purpose of the Disclosure: □ Insurance □ Legal □ Continuing care □ Personal

Specific description of the information to be disclosed: □ All Records

□ Hospital records □ Pathology reports □ Therapy records □ Radiology reports

□ EKG □ Mammogram □ Office notes □ Lab results □ Orders

If there is specific information you do NOT want disclosed, please advise the front desk staff.

I understand that the purpose of this authorization is for the use and/or disclosure of my protected health information (PHI) and that it may contain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by the Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my revocation must be submitted to the HIM Department. I understand that my revocation is not selective to the extent that the persons or the organizations in which I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to receive treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature.

I hereby authorize this medical facility and/or HealthMark Group to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.
I hereby release this medical facility and/or HealthMark Group from any liability which may result from this disclosure of confidential medical information, or which may arise of the result of the use of the information contained in the information released. Unless withdrawn, this consent will expire 180 days from the date signed.
This information may include Medical, Surgical, Psychiatric, Substance Abuse, and HIV/Aids information. I authorize that this information may be faxed when applicable.

Signature _____ Date _____