



CENTER for FOOT AND ANKLE RESTORATION

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I, _____
(Patient Name)

____/____/____
(Birthdate)

hereby authorize Orthopedic Specialists to

(Please check one only):

☐ **disclose the following medical information to:**

☐ **request the following medical information from:**

Clinic / Physician Name: _____

Address: _____

Phone #: _____ Fax #: _____

The specific information to release:

☐ complete records

☐ operative reports only

☐ other _____

☐ office visit notes only

☐ history and physical only

☐ xray notes only

☐ labs or test results ordered by Orthopedic Specialists

Records requested pertain specifically to my medical treatment date(s) of _____ through _____
The information is to be used for the specific purpose of:

☐ Second opinion

☐ Disability determination

☐ Attorney/ Legal purposes

☐ Insurance Company

☐ Personal use

☐ Other _____

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, and a communicable disease including HIV and AIDS. 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 the re-disclosure 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 Orthopedic Specialists 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 I understand that this consent may be withdrawn by me at any time except to the extent that action has already been taken in reliance upon it.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 90 days from the date below.

Orthopedic Specialists may charge an administrative fee for processing record requests. If such is the case, I will be informed, payment will be requested in advance, and 7-10 business days should be allowed for processing. Fees 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.

Printed Name: _____ Signature: _____ Date: _____

Relationship to patient: _____ Witness: _____ Date: _____

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records that are confidential. You are prohibited from patient 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 records or other information is not sufficient for this purpose.

REVOCATION:

I hereby revoke the consent given above.

Name: _____ Signature: _____ Date: _____

Relationship to patient: _____ Witness: _____ Date: _____