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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ Phone: _____

Address: _____

I, _____ HEREBY AUTHORIZE

Name of Hospital / Physician / Facility

PHONE: _____ FAX: _____

TO RELEASE INFORMATION SPECIFIED BELOW FROM MY MEDICAL RECORDS COVERING

THE DATES OF SERVICE _____ TO _____

THE INFORMATION WHICH IS CHECKED (X) BELOW IS TO BE RELEASED TO:

Andrew Cook, M.D.
Vital Health Institute
15055 Los Gatos Blvd., Suite 250
Los Gatos, CA 95032
Phone: 408-358-2511
Fax: 408-358-1009

CHECK OFF ITEMS BEING RELEASED

- | | |
|---|---|
| <input type="checkbox"/> OPERATION AND PATHOLOGY REPORTS | <input type="checkbox"/> HISTORY AND PHYSICAL REPORTS |
| <input type="checkbox"/> DIAGNOSTIC TESTS | <input type="checkbox"/> PROGRESS NOTES |
| <input type="checkbox"/> LABORATORY / X-RAY RESULTS, exclud HIV | <input type="checkbox"/> OTHER: _____ |

AND REQUEST THAT THE CHECKED RECORDS BE FAXED NO LATER THAN _____

This authorization for release of medical records form is valid now and will remain in effect until _____.
Furthermore, I understand that I may revoke this authorization at any time notifying this medical practice in writing. My
revocation will not affect actions taken by this medical practice prior to its receipt.

I understand that although federal law does not protect health information which is disclosed to someone other than
another health care provider, health plan, or health care clearinghouse, under California law all recipients of health care
information are prohibited from re-disclosing it except as specifically required or permitted by law.

BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS:

Patient: _____ Date: _____