AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth _____

I hereby authorize:

Carole Cook MD
PMB #246
6663 SW Beaverton Hillsdale Hwy
Portland, OR 97225

To send copies of my medical records to me at the following address:

_____
Address

_____
City State Zip

_____
Telephone

Processing Fee: $40 (checks payable to Carole Cook, MD)

_____ _____
Signature **Date**

Mail signed and dated release form along with $40 check to address noted above. You will receive copies of the past two years of records plus any significant procedures from your medical history. Allow 4 – 6 weeks to process.