Patient Name: _____ Date of Birth:_____
Address:_____ Phone:_____
City/State/Zip:_____ Medical Record #:_____

☐ I authorize Cole Memorial Medical Group to **SEND** information **TO**:	☐ I authorize Cole Memorial Medical Group to **RECEIVE** information **FROM**:
Name of Provider/Person/Facility	Name of Provider/Person/Facility
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone #/FAX# (include area code)	Phone #/Fax # (include area code)
Attention	Attention

Purpose for this request: (check all that apply). ***Note: Purpose is not required for patient access.***
☐ Healthcare ☐ Insurance Coverage
☐ Patient Request ☐ Legal Request ☐ Other – specify _____
Disclosure Format ☐Paper ☐ CD ☐ FAX (Providers Only) _____ _____ ☐ Other:_____
Method Received ☐ US Mail ☐ In-Person Pickup ☐ FAX (Providers Only) *(fax number):* _____
☐ Email: _____ ☐ Direct Address:_____
Type of information requested: (check all that apply and **MUST** include date(s) of service)
☐ X-ray reports ☐ Operative Report ☐ Discharge Summary ☐ History & Physical
☐ Laboratory test results ☐Complete medical record from _____ to _____
☐ Other (please specify) _____
Disclosure of Specially Protected Information: ☐ DISCLOSE
☐ Mental Health treatment ☐ Drug and/or alcohol abuse treatment ☐ AIDS or HIV virus
Information that I wish **NOT** to have disclosed, if any, includes:

I understand that:

- I understand that this Authorization is effective for a period of 90 days from the date of the signature unless otherwise specified below. No timeframe may exceed one year from the date of signature.
  If applicable, specify other expiration date/event here: _____
- I may revoke this authorization at any time by submitting a written request to the Cole Memorial Medical Group, 1001 East Second Street, Coudersport, PA 16915, except where disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care, medical insurance provider or otherwise not covered by privacy regulations; the information stated above could be re-disclosed and would no longer be protected by the privacy laws.
- My right to treatment cannot be conditioned on signing this authorization except when health services are provided solely for the purpose of disclosing information to a third party.
- A reasonable fee may be charged for the requested copies of the records.
- I have read the above and authorize the disclosure of the protected health information as stated. I also acknowledge that I may receive a copy of this form as requested.

Signature of Patient or Healthcare Agent/Representative _____ Date _____
Relationship to Patient (if Agent/Representative) _____ Date_____
Signature of Staff ___ _____ Date _____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION
FORM #100714-7; Revised 6/2021
COLE MEMORIAL MEDICAL GROUP