W. ALAN COOK, M.D.

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Hoover ~ Alabama ~ 35226
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AUTHORIZATION FOR RELEASE OF INFORMATION

( ) **I DO NOT** wish to have test results or other information released to any person other than myself.

( ) **I DO** wish to have test results or other information released to the following person(s).

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

It is the responsibility of the patient to notify this office of any changes in the above information. If changes do occur, the patient must file another Authorization for Release of Information with Dr. W. Alan Cook, M.D.

Patient Signature _____ Date_____

Witness_____