

Joseph L. Cooper, MD

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PATIENT AUTHORIZATION FOR MEDICAL INFORMATION

PATIENT NAME: _____

MED REC NUMBER: _____

SSN: X X X - X X - _____

DATE OF BIRTH: _____

I HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION TO:

FROM: **DUPLIN OB/GYN, PA / DR. JOSEPH L. COOPER**

MAILING: PO BOX 485 KENANSVILLE NC 28349-0485

PHONE: 910-296-1666 FAX: 910-296-1108 EMAIL: RECORDS@DUPLINOBYN.ORG

Information to be disclosed:

All records

Specific treatment date(s): _____

Lab reports Medication Sheets Discharge summary Problem List X-ray report(s) Progress Notes

Other: _____

This information will be used for: _____

This consent shall be valid for: **THIRTY (30) DAYS FROM THE DATE SIGNED**

I certify that this authorization is made free, voluntarily, and without coercion. I understand that the information to be released may include information regarding drug abuse, alcohol abuse, HIV infection, AIDS or AIDS related condition, psychological, psychiatric or physical impairments. I understand that the information to be released is protected under State and Federal laws and cannot be re-disclosed without my further written consent unless otherwise provided for by State and Federal law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it.

Patient Signature: _____ Date: _____

MEDICAL RECORDS USE ONLY

DATE SENT/FAXED: _____ INITIALS: _____

IMPORTANT WARNING: This information is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, you are hereby notified any dissemination, distribution, or copying of this information is STRICTLY PROHIBITED. If you have received this fax by error, please notify **Duplin Ob/Gyn, PA at 910-296-1666 immediately** and destroy the fax.