Joseph L. Cooper, MD
Mailing Address: PO Box 485, Kenansville, NC 28349-0485
Business Office Hours: Monday - Thursday 10am - 4:30pm
Phone: 910-296-1666 Fax: 910-296-1108

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@DUPLINOBGYN.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 my 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 in 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: _____