Designated Party Release

Cooper Pediatrics
3645 Howell Ferry Rd
Duluth, Georgia 30096
678-473-4738

You may give **Cooper Pediatrics** written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, x-ray, prescription refills, etc.) on your phone voice mail, fax, or another party that you designate.

Patient Name: _____ Date of Birth: _____

Date: _____ Account/Chart #: _____

At my request, I authorize **Cooper Pediatrics** to disclose my protected health information to:

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Please note any exceptions to the information that may be disclosed or released to the parties listed above:

HIV and STI testing is ***not*** included in the information released.

At my request, I also authorize **Cooper Pediatrics** to communicate my protected health information to me via the following methods:

☐ Leave detailed message on my cell phone voice mail (phone #: _____

☐ Fax detailed medical information (fax #: _____

Authorized Signature: _____ Date: _____

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will **not** affect any action **Cooper Pediatrics** took in reliance on this authorization before receipt of written notice of cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: _____