Release of Medical Information

I, _____,with a date of birth,_____, give my permission for
(patient name) (patient's DOB)

_____ to forward my medical records to Cooper Medical .
(name of company or physician)

Consent for release of medical records for _____
(patient name)

Date: _____

Requesting records from:

Name of Company or Physician:_____

Fax number:_____

Address:_____

Types of records we are requesting

☐ Any and all types of records you have for this patient

☐ Doctor's order
☐ Sleep Study
☐ CPAP/BiPAP Prescription
☐ History and physical
☐ Other:_____

Records within the following dates:

☐ **All records for this patient**

☐ **Records dated between _____and _____**

Please send records to:

Company: Cooper Medical

Attention: Kevin Cooper

At fax number: 706-622-2394

Email: customerservice@coopermedical.com

Or mail to: 115 John Maddox Dr, NW Suite A

Rome, GA 30165

For any questions please call: 706-266-4086

Patient's Signature_____ Date _____

Authorized Representative's Signature_____ Date_____

Relationship of Authorized Representative_____