**The Knee Center**

*David R. Cooper, M.D.*

**744 Kidder Street**

**Wilkes-Barre, PA 18702**

**570-825-5633**

**Authorization to Release Information**

Please list the people to whom we may speak or release your medical information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical information includes but is not limited to patient histories, office notes, test results, radiology results and films, referrals, consults, billing records, insurance records and records sent by other health care providers.

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

I have the right to revoke this authorization in writing at any time. I acknowledge that any such revocation is not effective to the extent that the above named persons or organizations have relied on the use or disclosure of my health information.

I have read this authorization and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

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Patient Signature Patient Name Date

