

# Kelly L. Cobb, M.D.

Internal Medicine  
Board Certified

605 Silverstone Rd., Ste 100 Lafayette, LA 70508  
Phone 337-266-9985 fax 337-266-4775

## AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

To comply with HIPAA guidelines, we need your permission to leave messages concerning your medical care.

Please check the appropriate lines that apply.

Leave message on answering machine.

Leave message on cell phone.

Leave message with spouse(Name) \_\_\_\_\_

Leave message with child(Name), \_\_\_\_\_

Leave message with other person{Name} \_\_\_\_\_

Do not leave message. Speak only with me.

Please check what information can be left.

Appointment time and date

Lab results

X-Ray results

Physical therapy information

Any medical information including appointments scheduled by this office for you with other doctors.

No information can be left.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that I may revoke this authorization in writing by sending a letter to the health care provider.

**Kelly L Cobb, M.D.**

Internal Medicine  
605 Silverstone Rd., Suite 100  
Lafayette, LA 70508  
Ph 337-266-9985 Fax 337-266-4775  
Authorization for Release of Medical Records

**\*PLEASE COMPLETE FORM PRIOR TO PATIENT'S SCHEDULED APPT\***

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

NAME OF DOCTOR (s)/FACILITY AND PHONE NUMBER MEDICAL RECORDS BEING REQUESTED FROM:

Previous Primary care Provider: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other Physicians: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician to receive records: Dr Kelly Cobb

Please bring in previous test results including the following:

- 1). Cardiac Workup
- 2). Imaging Studies
- 3). Lab History
- 4). Colonoscopy
- 5). Bone Density

Receipt of pertinent test results and/or records prior to your appointment will help the physician to access your needs and avoid duplicate testing.

Dates of service Health Information is covered by this authorization:  
Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Health Information related to the patient to be released under this authorization:

\_\_\_\_ Complete Health Record                      \_\_\_\_ Radiology Reports  
\_\_\_\_ Immunizations                                      \_\_\_\_ Specific Physician: \_\_\_\_\_  
\_\_\_\_ Lab Tests    \_\_\_\_ Other: \_\_\_\_\_

A photocopy/facsimile of this authorization may serve as an original.

\_\_\_\_\_  
Patient Signature                                      Date

\_\_\_\_\_  
Patient Representative                                      Date