Updated: 05/26/15

CORNERSTONE PEDIATRICS, P.C.
701 Will Halsey Way, Madison, AL 35758

AUTHORIZATION TO RELEASE OR OBTAIN MEDICAL INFORMATION

Patient's Name (print):_____

Birthdate:_____ Phone (home):_____ (work):_____

Address:_____

City:_____ State:_____ Zip:_____

I, the undersigned, authorize and request **Cornerstone Pediatrics, P.C.** to: ___ **release to** ___ **obtain from**

Physician/Parent/Patient:_____ Phone:_____

Address:_____

City:_____ State:_____ Zip:_____

Please release the following information from the medical records for care/treatment:

_____ Complete Record _____ Lab Results _____ Immunizations _____ Progress Notes _____ X-Ray Results
_____ Other_____
I specifically authorize the release of protected information regarding: ____Drugs/Alcohol ____HIV

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at: Cornerstone Pediatrics, P.C., 701 Will Halsey Way, Madison, AL 35758.

_____
Patient or Authorized Representative Date

_____
If not patient, relationship to patient

I understand that by signing this release, I will no longer have a relationship with Cornerstone Pediatrics and cannot expect any appointments to be made.

This authorization expires 90 days from date signed.

Please fax records to 256-461-7168 or mail them to the address above. If you have any questions, please call us at 256-461-7440.

Reason for Release of Records:
___ Transferring to another provider locally

Reason transferring:_____

_____

___ Moving out of town

___ Insurance Purposes

___ Other_____

We suggest that you keep a personal copy of any records you provide this office or this office provides you.