Cornerstone Pediatrics

3333 West Tech Rd. Suite 220
Miamisburg, OH 45342
Phone (937) 885-4475
Fax (937) 885-3670

Authorization for Release of Medical Information

PATIENT INFORMATION:

Print Patient's Full Name _____ Birth Date _____/_____/_____

Street Address _____
City State Zip

Social Security Number _____-_____-_____Home Phone (_____) _____-_____

I, _____, do hereby authorize
Name of Person Completing Form

_____
Name of Physician/Organization Address **(REQUIRED)** City State Zip Code **(REQUIRED)**

_____
Fax Number **(REQUIRED)** Phone Number **(REQUIRED)**

to release the following protected health information:

☐ ENTIRE CHART, including information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions

☐ OTHER _____

PLEASE RELEASE INFORMATION TO:

_____
Name of Physician/Organization Address **(REQUIRED)** City State Zip Code **(REQUIRED)**

_____
Fax Number **(REQUIRED)** Phone Number **(REQUIRED)**

PURPOSE OF DISCLOSURE:

☐ CHANGE OF DOCTOR ☐ PERSONAL ☐ OTHER _____
☐ CONTINUITY OF CARE ☐ LEGAL MATTER

Please provide the best telephone numbers in the event we may need to contact you (home, work, or cell):

Primary (_____) _____-_____ Secondary (_____) _____-_____

I hereby authorize disclosure of the health information for the above named patient. This authorization includes authorization to release information concerning HIV testing and/or treatment of AIDS, AIDS related conditions, drug and alcohol abuse, drug related conditions, alcoholism and psychiatric or psychological conditions . This authorization is valid for twelve (12) months from the date of my signature, unless otherwise specified. I understand that I may cancel this request with written notification, but that it will not effect any information released prior to notification of the cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____/_____/_____
Signature of Person Completing Form Relationship to Patient Date