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Medical Release of Information Form

ALL INFORMATION REQUIRED. PLEASE FILL IN ALL BLANK/HIGHLIGHTED INFORMATION

I, _____ do hereby acknowledge that I have requested the following medical record(s):

_____ Physical Exam/Well Visit. Date of Service:_____

_____ Progress Notes. Date of Service:_____

_____ Lab Work. Date of Service:_____

_____ Entire Record (some fee may apply)

Instructions:

_____

_____

_____

The records are pertaining to the following patient of Cornerstone Pediatric and Adolescent Medicine:

Name: _____ DOB: _____

Parent picked-up record(s) on _____
(Date)

Unless otherwise revoked, this Authorization will expire TWELVE (12) MONTHS from date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by confidentiality rules.

_____ _____
[Signature of Patient or Authorized Representative] [Relationship to patient] [Date]

_____
(Staff Initials)