Brett Wilson, MD, FAAP
William Rutledge, MD, FAAP
Richard Gelber, MD, FAAP
Vandana Nayal, MD, FAAP
Shefali Parmar, MD, FAAP
Kristin Donoghue, MD, FAAP

97 Cornerstone Drive
Cary, NC 27519
Tel: 919-460-0993
Fax: 919-481-3952

Theresa Kallman, MD, FAAP
Matthew Baldwin, MD, FAAP
Chitra Chandrasekaren, MD, FAAP
Kelly Carney, MD, FAAP
Ellen Ghodke, MD, FAAP
Priti Elkins-Williams, MD, FAAP

Medical Release of Information Form Transferring In

THIS AUTHORIZATION WILL EXPIRE TWELVE (12) MONTHS FROM THE DATE SIGNED.

Patient Name: _____ Date of Birth: _____

I request and authorize: _____
(Name of Physician and Clinic/Practice)
Address/City/State/Zip _____

Phone Number_____ Fax Number_____

Release the medical record of the above-named patient to:
Cornerstone Pediatric and Adolescent Medicine
97 Cornerstone Drive, Cary NC 27519
Phone: 919.460.0993 Fax: 919.481.3952

This request and authorization applies to: *Please initial next to the appropriate line. (Please initial only one)*

_____ ALL HEALTHCARE INFORMATION including immunization records, well and sick visits, labs, x-ray reports.
_____ MOST RECENT HEALTHCARE INFORMATION including immunization records, last physical exam with labs.

PLEASE ALLOW TEN (10) TO FOURTEEN (14) BUSINESS DAYS TO PROCESS YOUR REQUEST.

Please initial the following acknowledgement:
_____ I understand I have the right to revoke this authorization by providing a written request to do so to the above-named physician or organization. I understand that the revocation will not apply to information that has already been released.

_____ _____ _____
[Signature of patient or authorized representative] [Date] [Relationship to patient]

_____ _____
[Parent / Patient Phone Number] [Parent / Patient Email Address]

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