AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This form applies only to the release or disclosure of your health information. It is not consent for treatment and is not intended for any other purpose.

By signing this form, I authorize the release or disclosure of the protected health information (PHI) described below:

TO: Cornerstone Pediatrics
2700 Braselton Hwy, Suite 1
Dacula, Georgia 30019
Ph: 678-543-9400 Fax: 678-543-9420

FROM: Pediatric Office/Doctor
Name: _____
Address: _____
_____

Reason for transfer: _____

Note: This authorization expires upon fulfillment of request. Information will not be resent without another signed authorization.

Patient(s) full name _____ Date of Birth _____
_____ _____
_____ _____
_____ _____

I authorize the following information to be sent to the address above:
_____ Copies of all records for the period
_____ Copies of the information described below
_____ Problem list & vaccine record
_____ History & physical examination
_____ X-ray reports
_____ Lab reports
_____ Other (please specify)

From _____
To_____

I understand that this information is of personal medical nature and may include any history of or references to Acquired Immunodeficiency Syndrome (AIDS); Sexually Transmitted Diseases (STD's); Human Immunodeficiency Virus (HIV) infection; behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.
The following information should not be released, even if occurring during dates above: _____
Special requirements: certified mail, extended expiration date, and the like:_____

I have been provided a copy of Cornerstone Pediatrics LLC's notice of privacy practices and am aware that there are charges for copies of records made pursuant to this authorization. I understand that Cornerstone Pediatrics LLC assumes no responsibility for the subsequent use/misuse by others of my health information which was disclosed under this authorization. I release Cornerstone Pediatrics LLC from all legal liability that may arise from release of my information under this authorization.

SIGNATURE _____ Date _____
(parent or legal guardian)

The patient or their representative may revoke this authorization by notifying in writing to Cornerstone Pediatrics LLC. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Federal law also requires a statement that there is the potential that the protected health information released under this authorization may be subject to re-disclosure by the recipient. Any such re-disclosure is beyond the control of Cornerstone Pediatrics LLC.

Prepared by: _____ Date sent out: _____

****** PLEASE DO NOT FAX RECORDS OVER 15 PAGES ******