AUTHORIZATION FOR RELEASE OF INFORMATION

This form applies only to the release or disclosure of your health information. It does not serve as 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 ☐FROM ☐TO ☐FROM

Cornerstone Pediatrics _____

2700 Braselton Hwy, Suite 1 Dacula, GA 30019 _____

Ph: (678) 543-9400 **Fax: (678) 543-9420** _____

Reason for Transfer: _____

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

Patient(s) Full Name _____ **DOB** _____

_____ _____

_____ _____

_____ _____

I authorize the following information to be sent to recipient above:

_____**Copies of all records for the period**

_____**Problem List & Vaccine Record** **From: / /**

_____**History & Physical Exam** **To: / /**

_____**X-Ray/Lab Reports**

_____**Other (please specify)**

I understand that this information is of personal medical nature and may include any history or references to AIDS, STDs, HIV; behavioral health services/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions.

The following information should NOT be released, even if occurring during the dates above: _____

Special Requirements: Certified Mail, Extended Expiration Date, etc.: _____

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

Parent Signature _____ **Date** _____

The patient or their representative may revoke this authorization by notifying Cornerstone Pediatrics LLC in writing. 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 HIPPA. Federal law also requires a statement that there is potential that the PHI 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 _____

PLEASE DO NOT FAX RECORDS EXCEEDING 15 PAGES