CORNERSTONE
PEDIATRIC & ADOLESCENT MEDICINE

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Medical Release of Information

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

I, _____ [print name] do hereby acknowledge that I have requested the following medical record[s]

_____ Physical Examination form [well visit] (DOS _____)

_____ Progress Notes (DOS _____)

_____ Lab work (DOC _____)

_____ Entire record (some fees may apply)

Instructions:_____
_____
_____

The aforementioned records are pertaining the following patient of Cornerstone Pediatric & Adolescent Medicine:

Name: _____ DOB:_____

Parent picked up record[s] _____
[Date]

_____ _____
[Signature of Recipient/Relationship] [Date]

_____
Staff Initials

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 an unauthorized re-disclosure and the information may not be protected by confidentiality rules.