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97 CORNERSTONE DRIVE ♦ CARY, NORTH CAROLINA ♦ 27519
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Medical Release of Information Form
Transferring Out

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

Patient Name: _____

Date of Birth: _____

I request and authorize
Cornerstone Ped. And Adolescent Medicine
97 Cornerstone Dr. Cary, NC 27519
Phone: 919-460-0993 Fax: 919-481-3952

To release the medical record of the above-named patient to:

Name of recipient: _____

Address/City/State/Zip _____

Reason for release: _____

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.

NOTE: There is a **fee of \$25.00** for the first child and a **fee of \$10.00** for each additional child.

If patient is aging out of the practice or under the age of 1, no charge applied

_____ MOST RECENT HEALTHCARE INFORMATION **including** immunization records, last physical exam with labs.

NOTE: There is a **fee of \$5.00** for each child

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]