Brett Wilson, M.D., F.A.A.P
Mary R. Wedegaertner, M.D., F.A.A.P
William Rutledge, M.D., F.A.A.P
Richard Gelber, M.D., F.A.A.P
Vandana Nayal, M.D., F.A.A.P
Shefali Parmar, M.D., F.A.A.P
Kristin Donoghue, M.D., F.A.A.P

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

Priti Elkins-Williams, M.D., F.A.A.P
Theresa Kallman, M.D., F.A.A.P
Matthew Baldwin, M.D., F.A.A.P
Chitra Chandrasekaren, M.D., F.A.A.P
Margaret Kocsis, M.D., F.A.A.P
Lori Tackman, M.D., F.A.A.P
Sherill Steen, RPA-C

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 (of office listed above) _____

Phone: _____ Fax: _____

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

Cornerstone Ped. And Adolescent Medicine
97 Cornerstone Dr. 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*]

_____

[*Phone Number of patient or authorized representative*]