Brett Wilson, MD, FAAP
William Rutledge, MD, FAAP
Richard Gelber, MD, FAAP
Vandana Nayal, MD, FAAP
Shefali Parmar, MD, FAAP
Kristin Donoghue, MD, FAAP

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

Priti Elkins-Williams, MD, FAAP
Theresa Kallman, MD, FAAP
Matthew Baldwin, MD, FAAP
Chitra Chandrasekaren, MD, FAAP
Margaret Kocsis, MD, FAAP

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 Pediatrics and Adolescent Medicine 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.

*****REQUESTS WILL NOT BE PROCESSED UNTIL PAYMENT IS MADE*****
****PLEASE SUBMIT PAYMENT WITH REQUEST****

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]*