02/10

Cornerstone Health Care, PA

Please fax this form to Shapiro Eye Care at 336-274-5884 or email to annette.rachlin@gmail. There is a charge of $15 if we send you your records. There is no charge if we send your records directly to your doctor or if your doctor sends records to us.

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (Medical Record Release)

1. I hereby authorize (name of provider) _____to disclose the following information from the health records of:

Patient Name _____Date of Birth _____

Address _____

Telephone _____

Patient Number _____

Covering the period(s) of healthcare:

From (date) _____to (date) _____

2. Information to be disclosed:

____complete health record(s) _____discharge summary

____history & physical examination _____progress notes

____consultation reports _____laboratory tests

____x-ray reports _____other (please specify)_____

I understand that this will include information relating to (check if applicable):

____acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection

____behavioral health service/psychiatric care

____treatment for alcohol and/or drug abuse

3. This information is to be disclosed to_____ for the purpose of_____

4. I agree that a copy of this release or fax of this release shall be as valid as this original release.

5. Please send copies of all requested information as soon as possible to the address listed below:

_____

_____

Phone # _____Fax # _____

6. I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 12 months from the date of signature below.

7. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability

for disclosure of the above information to the extent indicated and authorized herein.
Signed:

_____

(patient) (date)

_____

or (legal representative) (relationship to patient) (date)

_____

(signature of witness) (date)