Cornerstone Family Medicine

Release of Information Authorization

Name: ____Date of Birth: ___________________
Address: ____
City/State/Zip: ____ Telephone: _______________________________

1) **Release Records To:** (**Where** do you want the information sent? **Who** may have the information?)	Name of individual, healthcare provider/hospital/practice: ____ Address: ____ City: _____________________________State: ____________ Zip Code: ____________ Phone Number: ______________________________ Fax Number: ________________________________
2) **Obtain Records From:** (**Who** has the information you want released?)	**Cornerstone Family Medicine** **206-A S Main St** **Greer, SC 29650** **Phone: 864-989-0230**
3) **Release Instructions:** (**How** do you want the information?)	Release Method / Format Requested: (check one) ☐ Hardcopy Format ☐ Facsimile ☐ Email: ____ ☐ CD
4)**Purpose of Release:** (**Why** is it needed?) I understand that fees for copies of medical records/images and postage fees may be charged as provided by S.C. Law.	☐ Continuing Care ☐ Military ☐ Legal ☐ Insurance ☐ Disability ☐ Patient Request ☐ School ☐ Other: _________________________
5)**Treatment Date (s):** (**When** were you seen?)	☐ Treatment dates from _____________ to _______________ (please be specific) ☐ All Treatment dates
6)**Information to be Released:** (**What** do you want sent or released?)	☐ Clinical Notes ☐ Laboratory Reports ☐ Immunization Records ☐ Billing Records ☐ X-ray Reports ☐ Old Medical Records ☐ Other: ______________________ ☐ All Medical Records

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, alcohol abuse, and/or results of tests for all infectious diseases including HIV / AIDS. I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Medical Records of CFM. I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end from one year from this date or _____________________________________.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed as provided by Federal and/or State Law. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving this information. I understand I have a right to a copy of this authorization. **Proof of identity may be required. (NOTE: Allow 30 days for processing according to Federal regulation.)**

____ ____
Printed Name of Patient or Legal Guardian/Representative **Date**

X____ ____
Signature of Patient or Legal Guardian Representative **Relationship to Patient, if Signed by Legal Guardian**