

CORNERSTONE PEDIATRICS

Authorization for Release of Medical Records and Other Protected Health Information (PHI)

Patient Name	Birth Date
Patient's Address	
City	State
Zip	

Authorizes	Release of Records To:				
Name of Physician Gary Griffith MD	Name of Physician				
Name of Health Care Facility Cornerstone Pediatrics	Name of Health Care Facility				
Address 298 Clear Sky Court Suite C	Address				
City, State, Zip Clarksville, TN 37043	City, State, Zip				
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Phone 931-444-9158</td> <td style="width:50%;">Fax 931-538-4673</td> </tr> </table>	Phone 931-444-9158	Fax 931-538-4673	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Phone</td> <td style="width:50%;">Fax</td> </tr> </table>	Phone	Fax
Phone 931-444-9158	Fax 931-538-4673				
Phone	Fax				

The healthcare provider requesting the authorization will receive no financial or in-kind compensation in exchange for using or disclosing the health information described herein.

Information to be Released		
<input checked="" type="checkbox"/> All Clinic Records <input type="checkbox"/> Progress Notes <input type="checkbox"/> Office Notes	<input type="checkbox"/> Allergy Records <input type="checkbox"/> X-Ray Reports <input type="checkbox"/> Lab Reports	<input type="checkbox"/> Immunization Records <input type="checkbox"/> Summary Report <input type="checkbox"/> Other (Specify)

For the Following Dates: _____

_____ (Initial)	I understand that the information above may contain mental health, developmental disabilities, alcoholism, AIDS test results, AIDS – related disease diagnosis, drug abuse or other privileged information.
_____ (Initial)	I understand that this authorization is valid for one (1) year unless otherwise stated or cancelled by me with written notice

Authorize Release of my medical records in accordance with the specification listed above

Signature of Patient / Guardian	Date
Printed Name of Patient / Guardian	Date
Witness:	Date:
Release of information date:	Signature: