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		Name of Physician **Gary G Griffieth MD**	
Name of Health Care Facility		Name of Health Care Facility **Cornerstone Pediatrics**	
Address		Address **298 Clear Sky Court Ste C**	
City, State, Zip		City, State, Zip **Clarksville, TN 37043**	
Phone	Fax	Phone **931-444-9158**	Fax **931-538-4673**

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		
X All Clinic Records	☐ Allergy Records	☐ Immunization Records
☐ Progress Notes	☐ X-Ray Reports	☐ Summary Report
☐ Office Notes	☐ Lab Reports	☐ Other (Specify)

(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: