Authorization to Release Protected Health Information
(Medical Record Release Form)

Patient Name: ______________________ Date of Birth: ____/____/____
Address: ______________________ Phone: ______________
MRN: __________

I hereby authorize:	**to release my medical record to:**
Practice: ______________	Other Practice or Person: ______________
Address: ______________	Address: ______________
City, State, Zip ______________	City, State, Zip ______________
Phone & Fax: ______________	Phone & Fax: ______________

Describe information to be sent and purpose for the release. If full medical record, please include date ranges:

____

____

Requesting Records from these Providers: ______________________

I understand that I may revoke this Authorization at any time. The revocation will not apply to information that has already been released in response to this Authorization or to my insurance company. If I fail to specify an expiration date or event or condition, this authorization will expire automatically in one (1) year from the date of signature. If I revoke this Authorization, I must do so in writing and submit my revocation to the Compliance and Patient Safety Department or my provider's office. I may refuse to sign this Authorization. Cornerstone will **not** condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on this Authorization.

Content and Protection of Authorization: Information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. I understand that the information released may include sensitive information related to behavioral and/or mental health records, drugs and alcohol, HIV/AIDS and other communicable diseases, and genetic testing. It is possible that, once disclosed, the privacy of the information will no longer be protected under federal privacy law. I understand a fee may be charged for copying my medical records.

I have read and understand the information in this Authorization form.
(A witness signature is **always required**. When a verbal consent to release records is provided, two Cornerstone employees must sign: one as the Authorized Representative and one as the Witness.)

______________________________ ______________
Signature of Patient Date

______________________________ ______________
Signature of Authorized Representative (if applicable) Date

____
Representative's Relationship/Authority to make request on behalf of patient (if applicable)

______________________________ ______________
Witness Signature (Required) Date

As of: 08/15 **UNWITNESSED REQUESTS WILL NOT BE PROCESSED**