Cornerstone Medical Clinic Authorization to Release and Disclose Patient Information

Last Name:_____ First Name:_____ Middle Name: _____

Mailing Address: _____ City:_____ St. ___ Zip:_____

Date of Birth: ___/___/___ Sex: _____Male _____Female

Phone Number: _____ Secondary Phone Number:_____

Records Released From

Cornerstone Medical Clinic

1825 Academy Dr. Anchorage, AK 99507

(p) 907-522-7090 (f) 907-339-8786

Records Released To

Name: (i.e. Health Facility, Provider): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number:_____ Fax Number:_____

Information To Be Released

____All Clinic Records (office visits, lab, radiology, medicines, immunizations)

____Billing history – (specify dates needed) from ___/___/___ TO ___/___/___

____Radiology Reports ____Lab Reports ___Progress/Clinic Notes ___Immunization Records

____History & Physical Exam ___Operative Report ____Consultations ____Emergency Record

____Pathology Report ____Medication & Allergy Record ____

____Drug/Alcohol Abuse Information ___Mental Health ___HIV/AIDS

Release Instructions (Please allow up to 30 days for processing)

____Mail ____Fax (if record is too large it will be mailed even if this option is checked)

____Patient Pick up(person authorized if other than patient)_____

- I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment.
- Unless otherwise revoked in writing, this authorization expires one year after the date you sign it.
- At any time I may revoke this release by submitting an notice in writing to CMC . A revocation will not change release that happen before the revocation.
- A photocopy/fax of this authorization will be treated in the same way as an original .
- CMC may include records that we receive from other organizations if these records have been used by CMC and filed in the record CMC maintains about you.
- CMC cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by the state and federal privacy protections after it is released. By signing this authorization, you release CMC from any and all liability resulting from a re-disclosure by the recipient.
- Your signature indicates that you have read and understand this form. And authorize release of your information as described above.

Signature:_____ Date: ___/___/___