CORNERSTONE
PRIMARY HEALTHCARE

117 Maple Row Blvd.,
Hendersonville, TN 37075
Phone (615)824-1616 Fax (615) 824-1622

MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize the following healthcare provider(s) and its physicians, employees and agents to release or disclose to Cornerstone Primary Healthcare all of my medical records including records pertaining to treatment, prognosis and diagnosis, including any specially protected or listed records, such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection.

Provider	**Address**	**Phone Number**
_____	_____	_____
_____	_____	_____

I further authorize you to provide to and discuss with Cornerstone Primary Healthcare any confidential information with respect to my medical condition or treatment, either formally or informally.

Release Records to: **Cornerstone Primary Healthcare**
117 Maple Row Blvd.,
Hendersonville, TN 37075

Purpose of Disclosure: For use in continued medical care

Patient's Name: _____ **SSN:** _____ **Date of Birth:** _____

Records to release:
_____ All Records
_____ All Laboratory Results
_____ Records from _____ to _____
_____ The following specified records: _____

I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the above-named healthcare provider(s) before the healthcare provider(s) received my revocation. Should I desire to revoke this Authorization, I must send written notice to the healthcare provider(s).

I understand that I am not required to sign this Authorization. The above-named healthcare provider(s) will not condition treatment, payment or eligibility on whether I provide this Authorization.

I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the above-named healthcare provider(s) ability to use or disclose my information for treatment, payment, or healthcare operations, or as otherwise permitted by law.

I further understand and acknowledge that I am responsible for all costs associated with the provision of the information described herein to Cornerstone Primary Healthcare.

Patient/Guardian's Signature: _____ **Date:** _____

Relationship to Patient: _____

THIS AUTHORIZATION WILL EXPIRE 5 YEARS FROM DATE ABOVE. A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.