

Authorization to Disclose Health Information

I authorize Cornerstone Ob-Gyn to disclose the health information of:

Patient Name: _____
FIRST MI LAST
Date of Birth: _____ SS#: _____

This information may be disclosed to:

Name: _____
Address: _____
STREET APT# CITY STATE ZIP
Purpose of disclosure: _____

IMPORTANT NOTICE:

I understand that my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), behavioral or mental health services, and treatment for alcohol and drug abuse.

PLEASE RELEASE THE FOLLOWING RECORDS:

☐ Complete Medical Record - OR - ☐ Specific Records Only (see below)

ONLY THESE SPECIFIC RECORDS ARE TO BE RELEASED:

- | | |
|--|--|
| ☐ Problem List | ☐ X-Ray/Imaging Reports from ____/____/____ to ____/____/____ |
| ☐ Progress Notes | ☐ Laboratory Results from ____/____/____ to ____/____/____ |
| ☐ History/Physical Exam | ☐ Genetic Testing Information |
| ☐ Medication List | ☐ Other Diagnostic Reports (Specify) _____ |
| ☐ List of Allergies | ☐ Other (Specify) _____ |

If I fail to specify an expiration date, this authorization will expire in 6 months.

Date, event, or condition this authorization will expire:

IF LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE 6 MONTHS FROM THE DATE OF SIGNATURE.

I understand that:

- This information is released for the specific purpose stated above. Any other use without written consent is prohibited.
- I have the right to revoke this authorization at any time by notifying Cornerstone OB-GYN in writing. Revocation does not apply to information already released or actions already taken.
- Revocation does not apply to my insurance company when the law provides my insurer with the right to contest a claim.
- Information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal confidentiality rules.
- I do not need to sign this form to ensure treatment. However, I may need to sign to obtain insurance benefits or participate in research studies.
- I may inspect or copy the information disclosed as provided in CFR 164.524.

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

DATE

If signed by authorized representative:

Printed Name: _____

Relationship to Patient: _____

COMPLETE ONLY IF RECORDS ARE BEING RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can properly interpret. I have been advised to contact my physician regarding entries in my medical record to prevent misunderstanding. I will not hold Cornerstone OB-GYN, its staff, or its providers liable for any misinterpretation of information in my medical record resulting from failure to consult my physician for correct interpretation.

SIGNATURE

DATE