Cornerstone Pediatrics 90 Health Park Drive, Suite 160
Louisville, CO 80027
(303)673-9030 (303)604-1095 - Fax

REQUEST FOR RELEASE OF MEDICAL RECORDS TO CORNERSTONE PEDIATRICS

Patients Name
Last _____ First_____ D.O.B._____

I authorize _____ to disclose the following specified health care information below to the above named organization on this request. Phone number _____ Fax number _____ to contact them to get records.

<u> WE MUST HAVE A PHONE NUMBER AN DFAX NUMBER IN ORDER TO COMPLETEE THIS REQUEST**</u>**

Please initial all information you <u>DO NOT</u> want to release:
_____ Drug Abuse, if any _____ Substance abuse, if any
_____ Psychological or psychiatric conditions if any _____ AIDS/HIV if any

This information <u>is to be released</u> now:
_____ Release of records to another medical facility

I understand that I may cancel this authorization to release information at any time. I also understand that once the information has been given out in good faith: I cannot stop it from being used. I understand that the information released is not to be disclosed to any other individual agency without my further written permission. This consent will automatically expire one (1) year after the date signed or when it is no longer needed for the purpose stated above, whichever is later.

Person authorized to sign for the patient(s):

_____ _____ _____ _____
Print Name Relationship Signature Date

_____
Best Phone number to be reached during business hours