AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Cornerstone Medical Center • 1041 Kirkpatrick Road, Suite 100 • Burlington, NC 27215
A Member of Alamance Regional Physicians Care

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that if the organization authorized to receive the information is not an insurance company, health care provider, or other covered entity, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ Date of Birth: ___/___/___ Social Security #: _____-____-_____
First Middle Last

The following healthcare facility is authorized to release the requested health information:

Facility Name: Cornerstone Medical Center_____ Telephone Number: 336-538-0565_____
Address: 1041 Kirkpatrick Road, Suite 100____ Fax Number: 336-538-0564_____
Burlington, NC 27215_____

Please note the date(s) of service being requested: From: ___/___/___ To: ___/___/___

Please check and initial the specific information being released (used or disclosed):

____ Entire Record ____ Lab Results ____ Office Notes ____ Physician Orders
____ Radiology Reports ____ Consult Reports ____ Operative Reports ____ Other_____

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, sickle cell anemia, psychological or psychiatric impairments, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS, AIDS related complex (ARC) and/or human immunodeficiency virus (HIV).

This information may be released to and used by the following individual / organization:

Name: _____ Telephone Number: _____
Address: _____ Fax Number: _____
_____

Will the health care provider requesting the authorization receive any financial or in-kind compensation in exchange for using or disclosing the health information described above?

☐ Yes ☐ No

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Purpose of Disclosure:
☐ Medical Review ☐ Legal Review ☐ Insurance Review ☐ Personal Use ☐ Other:_____

I understand that I have a right to revoke this authorization at any time by notifying the Health Information Department of the providing organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this private health information is voluntary. I can refuse to sign this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits may not be conditional based on signing this authorization. I understand that I may inspect or obtain a copy of the information to be disclosed. I understand that this authorization will expire in 90 days.

Printed Name: _____ Signature: _____ Date:____/___/_____

Patient/Authorized Representative Verified by: Drivers License _____ Other _____

If Authorized Representative, please indicate relationship to patient:

☐ Spouse ☐ Parent ☐ Other

**Please note, if information relating to the treatment of drug or alcohol abuse is being released, for a patient under the age of 18, the patient must also sign this authorization.

Signature of Minor: _____