CORNERSTONE HEALTH
Medical • Counseling • Recovery

Authorization to Release and Disclose Patient Information

Full Legal Name: _____ Date of Birth: _____

Mailing Address: _____ City:_____

State: _____ Zip:_____ Phone Number: _____ Secondary number: _____

Records Released From:

Cornerstone Health Medical 2121 ABBOTT ROAD ANCHORAGE, ALASKA 99507

Phone: 907-522-7090 Fax: 907-522-7095

Records Released To:

Name of facility or provider: _____

Physical Address: _____ City:_____

State: _____ Zip:_____ Phone Number: _____ Fax number: _____

Information to be Released:

- ☐ All Clinic Records (visit notes, lab results, radiology reports, medication list, immunization history, operative reports) Date range: _____/_____/_____ through _____/_____/_____
- ☐ Billing History (specific date range required) _____/_____/_____ through _____/_____/_____
- ☐ Radiology Reports ☐ Lab Reports ☐ Pathology Reports ☐ Progress/Clinic Notes
- ☐ Operative Reports ☐ Immunization Records ☐ Consultation Notes ☐ Emergency Records
- ☐ History & Physical Exam ☐ Medication & Allergy Records ☐ Other: _____

_____

Release Instructions (Processing may take up to 30 days.)

☐ Mail ☐ Fax *Please Note: If the record is too large it will be mailed regardless of the chosen option*

☐ Patient Pick-up (authorized person 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 it is signed.
- At any time, I may revoke this release by submitting a notice in writing to CMC. A revocation will not change release that happened prior to revocation.
- I understand that a photocopy or fax of this authorization will be treated the same way as the original.
- CMC may include records that we receive from other organizations if these records have been used by CMC and filed in the record that CMC maintains about me.
- CMC cannot prevent re-disclosure of my information by the person or organization who receives my protected information after it is released. I understand that by signing this authorization, I release CMC from all liability resulting from re-disclosure by the recipient.

Your signature below indicates that you have read and understand this form and authorize the release of your protected health information (PHI) as described above.

Signature: _____ Date: _____