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 Self:

Full Legal Name: _____ Date of Birth: _____

Please note that there is a fee of $0.50/page up to 100 pages and $0.25/page thereafter that is due upon order of records. There is no circumstance in which this fee is waived and must be paid at the time of service.

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: _____