Cornerstone
Clinic for Women
OBSTETRICS AND GYNECOLOGY

- Kay Chandler, MD
- Kenneth Singleton, MD
- Kevin Breniman, MD
- Matthew Sellers, MD
- Jennifer Anderson, MD
- Nathan Livers, MD
- Kristen Bracy, MD
- Lisa Grummer, APRN
- Rachel Ashcraft, APRN
- Megan Tucker, APRN
- Christa Jackson, APRN
- Jennifer Wilson, APRN
- Lindsey Galloway, APRN
- Sarah Holland, APRN
- Robin Koontz, APRN
- Angie Titus, APRN

Authorization to Release Medical Records

Patient ID #_____
(CCWF use only)

Patient's full name: _____ Date of birth: _____
Street address: _____ City, State, zip: _____
Telephone number: _____

****** *These records are released for the PURPOSE OF:*** _____

I hereby authorize the released and disclosure of the following specific medical information. My authorization extends only to those date elements/documents initialed below. I must show a picture ID when picking up records.

Initial any or all that apply:

_____ Records of all visits
_____ Discharge Summary
_____ History and Physical Examinations
_____ Hepatitis information
_____ Statements of charges or payments
_____ Progress Notes
_____ Consultation Reports
_____ Records of visits for a specific date or dates. Specific dates includes or are limited to: _____
_____ Copies of records or reports to be provided to the below named hospital, lab, clinic, etc.
_____ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Information
_____ All of the Above
_____ Other (Be Specific) _____

Released Records:

____ ***TO*** ____ ***FROM***

Cornerstone Clinic for Women
1 Lile Court Suite 200
Little Rock, AR 72205
Office 501-224-5500 Fax 501-224-1166

____ ***TO*** ____ ***FROM***

Name (first & last): _____
Address _____
City, State, Zip: _____
Telephone: _____
Fax: _____

This authorization is given freely with the understanding that: 1) any and all records whether written or oral or in electronic form, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law. 2) a photocopy of the fax of this authorization is as valid as this original. 3) I may revoke this authorization, at any time except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist. 4) Cornerstone Clinic for Women, its employees, officers, and physicians are hereby released from any legal responsibility of liability for disclosure of the above information to the extent indicated and authorized herein. 5) treatment, payment, enrollment or eligibility for benefits may not be conditioned upon obtaining the authorization. 6) information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

_____ _____ _____
Today's date Patient's printed name Patient's signature (or guardian, if a minor)

_____ _____
Expiration date (if other than one year from above date) Social Security # (for Identification purposes only)

_____ _____
Patient's personal representative Date

_____ _____
Patient's personal representative's authority to act Witness

SPECIFIC AUTHORIZATON FOR RELEASE OF DRUG/ALCOHOL ABUSE INFORMATION AND/OR MENTAL HEALTH INFORMATION - I acknowledge that data to be released MAY INCLUDE material that is protected by Federal law and that is applicable to EITHER Drug/Alcohol or Mental Health Information or BOTH. My signature authorized release of all such information (as specified above and for the purpose mentioned above.)

In order for the above information to be released, **YOU MUST SIGN HERE AND ABOVE.**

_____ _____
Signature Date