CORNERSTONE
MEDICAL MANAGEMENT, LLC

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Name of Patient (please print): _____ Birth Date: _____

Street Address: _____ City, State, Zip Code _____

I hereby authorize:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Phone: _____

To disclose my protected health information, as describe below, to:

Dr. Gerald K. Brantley
Dr. Terry E. Ham Jr.
1023 Keith Drive
Perry, Georgia 31069

PHONE: (478) 988-1100
FAX: (478)988-8211

Information to be released:

- ❑Medical History, Examination Reports
- ❑Treatment or Tests
- ❑X-Ray Reports
- ❑Laboratory Reports
- ❑HIV Test Results *
- ❑Mental Health
- ❑Sexually Transmitted Diseases*
- ❑Alcoholism
- ❑Surgical Reports
- ❑Hospital Records including Reports
- ❑Developmental Disabilities
- ❑Prescriptions
- ❑Consultations
- ❑Allergy Records
- ❑Drug Abuse

* A listing of the statutory exceptions to release HIV/STD test results without consent is available.

Purpose for Need of Disclosure:

❑At the request of the individual.

❑Other (Please Specify) _____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive A Copy of This Authorization**.
- **Refuse To Sign This Authorization** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization**, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s): **30 days after dated signature below.**

Signature of Patient (or Legal Representative) _____ **Date** _____

If signed by Legal Representative:

Relationship to Patient (Authority to act on patient's behalf) _____ Date: _____