CORNERSTONE MEDICAL MANAGEMENT, LLC
OFFICE OF
TITUS A. TAUBE, MD

200 S. Houston Lake Road • Suite B
Warner Robins • Georgia • 31088
Phone: (478) 953-1800
Fax: (478) 953-1931

Authorization For Medical Records Release

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

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Number: _____

I give authorization to the Office of Dr. Titus A. Taube/Cornerstone Medical Associates, LLC to disclose or release the following medical records:

❒ Pathology and Lab Records	❒ Radiology and X-Ray Records	❒ Vaccination Records
❒ Prescription and Medication Records	❒ Medical Exams	❒ Other ❒All Records
❒ Drug Screens**	❒ HIV Records**	❒ STD Treatment**

The above listed records are for services provided on date(s): _____ or ❒All Records

The above listed records should be released to the following listed persons:

Name: _____

Address: _____

Phone: _____ Fax: _____

The information released may only be used for the purposes listed below:

❒ For Medical Reasons ❒ Insurance Purposes ❒ Employment Purposes

IF THE REQUESTED RECORD CONTAINS INFORMATION PERTAINING TO ***PSYCHIATRIC, DRUG OR ALCOHOL TREATMENT OR CONTAINS HIV RELATED INFORMATION***, YOU MUST **SPECIFICALLY CONSENT TO THE RELEASE OF SUCH INFORMATION BY INITIALING ONE OR BOTH OF THE FOLLOWING:**

_____ I understand that if my records contain information pertaining to psychiatric, drug or alcohol treatment, such information will be released pursuant to this consent form.

_____ I understand that if my records contain confidential HIV information, such information will be released pursuant to this consent form. Confidential HIV related information is any information indicating that a person had an HIV related test, or has HIV related illness or AIDS, or any information which could indicate that a person has been potentially exposed to HIV.

This authorization is valid for (1) one year from the date of the patient's or patient representative's signature unless otherwise specified: _____.

I have read this form front and back and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above. I understand that this authorization is voluntary and it gives the authorized persons permission to use them as stated.

_____ _____

Patient Signature (or Legal Representative): Date:

CORNERSTONE
MEDICAL MANAGEMENT, LLC
300 Margie Drive • Warner Robins, Georgia 31088
Phone: (478) 751-2580
Fax: (478) 953-6727

Authorization For Medical Records Release

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your special authorization before we may use or disclose your protected health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form. ***DO NOT SIGN A BLANK FORM.***

SPECIFIC UNDERSTANDINGS

- By signing this authorization form, you authorize the use of disclosure of your protected health information (PHI). This information may be redisclosed if the recipient(s) described on this form is not required by law to protect the privacy of the information
- If you are authorizing the release of HIV-related information, psychiatric, and/or alcohol or drug treatment information you should be aware that the recipient(s) is prohibited from redisclosing any of this specific information without your authorization unless permitted to do so under federal or state law. You also have a right to request a list of people who may receive or use this specific information without authorization.
- In addition to the Health and Insurance Portability and Accountability Act (HIPAA) of 1996, the release of alcohol and substance abuse information will be in accordance with 42 CFR part 2, 45 CFR Parts 160 and 164.

YOUR RIGHTS ARE:

- You can refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.
- You can request to see and copy the information described in the authorization form in accordance with office policies.
- If you sign this authorization, you have the right to revoke it at any time, except to the extent that the provider has already taken action based upon your authorization. To revoke this authorization, please write to: Privacy Officer/ Cornerstone Medical Management/Associates, 300 Margie Drive, Warner Robins, Georgia 31088.