DISCLOSURE AUTHORIZATION FORM
FOR RELEASE OF PROTECTED HEALTH INFORMATION

Date: ________________

Patient Name: ______________________________________ D.O.B. ___________

Guarantor Name: ___________________________________ PT # ______________

COMMUNICATION OF HEALTH INFORMATION

I give permission to Cornerstone Medical Associates (Pediatric Associates) to disclose and discuss any information related to the medical care of my child, (Above Patient) with the following individuals:

______________________________ ________________________

Name Relationship

______________________________ ________________________

Name Relationship

Preferred Method of Contact

_____ Home _____ Cell _____ Work

Best Number: __________________________ Phone carrier: _________________

( ) OK to leave a message with detailed information on voicemail

( ) Leave message with call-back number only

( ) OK to leave message with family member or persons living in the household

_____________________________ ________________

Signature of guarantor Date

____

Printed Name