Patient Name/ DOB:

CORNERSTONE
PEDIATRICS

Dianne McNeill, M.D., FAAP
www.cornerstonepediatricsva.com

Authorization to Use or Disclose Protected Health Information

Medical Records Release

At my request, I authorize:

PRIOR Practice/Physician name: _____
Address: _____
Phone:_____
Fax: _____

To Disclose/Transfer the Following Information:

_____All Records
_____Immunization/Vaccine Records (_____please fax to 410-9640 ASAP)
_____Other (Specify)_____

To Disclose/Transfer records to:

Dianne McNeill, M.D., FAAP
Cornerstone Pediatrics
308 Cedar Lakes Drive, Suite 103
Chesapeake, VA 23322
Phone 757-410-9600
Fax 757-410-9640

Purpose of Disclosure:

_X_ At the request of the patient/legal guardian

*I understand that I may revoke this authorization at any time by notifying the office in writing. I understand that this authorization expires 1 year from the date signed.
*I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws/regulations.
*I understand that photocopy or facsimile of this authorization is as valid as the original.
*I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individuals protected health information.

Signature of Patient/Legal Guardian Relationship to Patient Date