Release/Provide Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Indiana and Federal laws concerning the privacy of such information.

Authorization: I hereby authorize:

Name:_____
Address:_____
Phone:_____Fax:_____

To furnish to: *Jackie Evans, MD, Theresa M. Krueger, MD, Mary Ian McAteer, MD, Emily M Glass, PA*
Cornerstone Family Physicians, PC
8902 N. Meridian Suite 230
Indianapolis, Indiana 46260
317-581-8888
FAX 317-705-7180

Medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment for:

_____Date of Birth:_____
(Print first and last name)

Information to be released:_____
This information is to be used for the following purpose:_____
Duration: This authorization is effective immediately and remain in effect for 12 months from the date signed, unless amended in writing.

Signature_____Date_____
(Patient/Parent/or Legal Guardian)

Print Name:_____Relationship to Patient:_____

Witness:_____Relationship to Patient:_____