9310 Old Kings Rd South, Suite 1303
Jacksonville, FL 32257
Tel. No. : 904.900.3472
Fax No. :904.503.2373

Request of Medical Records

Records to be sent to the following address:

NAME: CORNERSTONE FAMILY MEDICINE LLC

ADDRESS: 9310 OLD KINGS RD. SOUTH SUITE 1303, JACKSONVILLE FL 32257

FAX: 904.503.2373

Records to be obtained from the following Physician/Facility:

Physician/Facility: _____

Address: _____

Telephone: _____ Fax: _____

Reason for release of records: _____

Dates of Service requested are: _____

I understand that the records being disclosed contain PHI. Consent [is given to disclose the following: (check all that applies)

- ☐ All Medical Records
- ☐ Treatment Plan(s)
- ☐ HIV Test Results
- ☐ Bio Psychosocial Assessment
- ☐ Sexually Transmitted Diseases
- ☐ Hospital Notes
- ☐ Diagnostic Results (X-Ray/CT/MRI)
- ☐ Psychiatric evaluation(s)
- ☐ Accounting of Disclosures
- ☐ Physician's Progress Notes
- ☐ Medication Record/Prescriptions
- ☐ Laboratory Results
- ☐ Other: _____

As part of the medical record, the following information will be released unless prohibited:

SEXUAL ABUSE INFORMATION
DRUG AND ALCOHOL INFORMATION
CHILD ABUSE AND NEGLECTED INFORMATION
PSYCHIATRIC INFORMATION
AIDS/HIV

I have carefully read this consent, understand its contents and authorize the release of the above-specified information. This information is for the person/facility to which is addressed only. This information is protected by the federal law. The information is used or disclosed pursuant to this authorization maybe subject to disclosure by the recipient and no longer protected by federal law. I may cancel this authorization in writing at any time. This authorization will expire in one year from the date of signature.

Signature _____ Date _____

Patient Name _____ Date of Birth _____ / _____ / _____

If patient is unable to sign due to mental or physical disability or is a minor, authorization must be signed by the legal guardian.