825 N Main Street, Suite 1
Harrison, AR 72601
(870)743-4900

Steve Shrum, M. D.
Board Certified Internal Medicine
Board Certified Pediatrics

Dixie Shrum, P.N.P.
Board Certified Pediatric Nurse Practitioner

Jennifer Martin, F.N.P.
Board Certified Family Nurse Practitioner

Desiree' Looper, F.N.P.
Board Certified Family Nurse Practitioner

Medical Records Release of Information

Patient's Name _____

Date of Birth _____ Social Security Number _____-_____-_____

The undersigned hereby authorizes and requests medical records to be released **TO**:

Physician/Provider Name: Steve Shrum, M.D. Dixie Shrum, APN Jennifer Martin, FPN Desiree' Looper, APN

At Cornerstone Medical Clinic **Phone Number**: 870-743-4900

Address 825 N Main Street, Ste. 1 City, State, and Zip Harrison, AR 72601 **Fax:** 870-743-4949

FROM: Dr._____ at_____
Physician's name Clinic, Hospital, or Facility name

_____ _____,_____ _____
Mailing address City State Zip Code

_____ _____
Phone number Fax number

____ Complete Medical Records
____ Office Notes and Diagnostic Data for clinic dates from _____ to _____.

This information will be used for ___ Transfer of Care (Released from above practice) ___Referral/Specialists Care
____ Other, Please Specify_____

I understand that my medical records may include HIV, psychiatric, alcohol or drug abuse information. This information may be protected by federal and state regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described below. If you do not want certain portions of your medical records released, please initial the information you do not want released. ___

Substance Abuse ___Psychological/Psychiatric Treatment ___ HIV/AIDA/STD ___Genetic Information___

SPECIFICATIONS OF THE DATE, EVENT, OR CONDITION UPON WHICH THIS CONSENT EXPIRES (if left blank this consent expires one year from the date executed)

Executed this _____day of _____ 20____ _____
(Patient's signature)

_____ _____
(Witness) (Signature of parent, guardian, or Authorized Representative)

Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5000 in the case of each subsequent offense.