CORNERSTONE FAMILY HEALTHCARE

Miles of Hope Medical Gap Grant Applicant

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby request and authorize: **Cornerstone Family Healthcare/Elci Mejia/Ariana Jimenez**
(Person or Agency Requesting Information)

Address: 2570 Route 9W, Suite 10, Cornwall, NY 12518

To obtain information from: _____
(Person or Agency Providing Information)

Address: _____

Phone: _____ Fax: _____

The following information: X Breast Cancer Dx

From the Medical Record of:

Name: _____ D.O.B ____ /____ /____

For the purpose of: *Miles of Hope Breast Cancer Foundation Medical Gap Grant*

All the information I hereby authorize to be obtained from this Agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for ninety (90) days **unless** I specify an earlier expiration date here: ____ /____ /____ .
I understand that I may withdraw this consent at anytime. I further understand that portions of my records may be protected under federal confidentiality regulation (42 CRG Part 2 Article 27-F (PHL) and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that this consent is only for the specific purpose stated and may be revoked at any time. This consent expires automatically when its purpose has been accomplished. I further acknowledge that this form was fully explained to me and that this consent is given of my own free will.

Section 18 of the Public Health Law permits patients or their representative to have access to patient information contained on their medical records within ten (10) days. The patient/qualified requester is required to provide verification of identity prior to inspection or receiving copies of medical information. Individuals requesting access in the capacity of a guardian or conservator must provide copies of their appointment papers.

DATE: ____ /____ /____

_____
(Signature of Client or Legal Representative)

_____
Witness **if other than client**

_____
Legal Representative's Relationship to Client

FOR PROVIDER AUTHORIZATION ONLY:

Please Release: The Information Requested

Signature: _____ Date: _____

Corporate Headquarters
2570 Route 9W, Suite 10 ● Cornwall ● NY 12518 | (845) 220-3100 |www.cornerstonefamilyheathcare.org
Cornerstone Family Healthcare is a non-profit, multi-disciplinary community health center that believes that health care is a right and not a privilege.

Revised: 8/2022