Cornerstone
FAMILY MEDICAL GROUP
A PROFESSIONAL CORPORATION

1444 Florida Ave. #202
Modesto, CA 95350
(209) 524-1264
Fax: (209) 524-8218
cornerstonefpmg.com

HIPAA CONSENT FORM

Authorization to release medical information to other individuals

Date: _____

Patient's Name: _____

Patient's Date of Birth: _____

Patient's Social Security Number: _____

I hereby authorize **Cornerstone Family Medical Group** to release my Protected Health Information either verbally or in printed form to the following persons:

Name	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

This authorization shall remain in effect until: _____

_____

Patient's Signature **Date Signed**

01-12