FREDERICKSBURG FAMILY CLINIC, PA
d/b/a/ CORNERSTONE CLINIC

200 W. WINDCREST ST., FREDERICKSBURG, TX 78624, 830.997.0330
815 FRONT ST., COMFORT, TX 78013, 830.995.5633

Patient Name:_____ **Date of Birth:**_____

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION (PHI)
Effective September 23, 2013, Revised July 2015

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our notice **before** signing this consent and prior to any service being provided to you by the practice. The Practice reserves the right to change the Notice of Privacy Policies. If we change our notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer or by asking the provider's receptionist. You can also obtain a copy on the clinic's website at www.cornerstoneclinicfbg.com.

I authorize Physicians/staff of CORNERSTONE CLINIC to release information pertaining to my condition and/or care to those individuals listed below:

	Full Name	**DOB**		**Full Name**	**DOB**
Spouse:			Children:		
Parent:					
Children:			Other:		

CORNERSTONE CLINIC physicians/staff may contact me in the following manner (check all that apply):

HOME TELEPHONE NO:_____
- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with family member
  Who? _____

CELLULAR TELEPHONE NO:_____
- ☐ OK to leave message on voicemail with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to receive text message

WORK TELEPHONE NO:_____
- ☐ OK to leave message on machine with detailed message
- ☐ OK to leave message with call-back number only
- ☐ OK to leave message with co-worker
  Who?_____

WRITTEN COMMUNICATION
- ☐ OK to mail to my home address
- ☐ OK to mail to my work/office address
- ☐ OK to fax to this number_____
  ***See fax policy below.**

Cornerstone Clinic is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of faxing, third parties may have access to messages. When communicating from work, you should be aware that some companies consider faxes corporate property and your messages may be monitored. I understand that this office will not be responsible for information loss or delayed, or breaches in confidentiality that are due to technical factors beyond this clinic's control. **I understand and agree to this fax policy**. _____(initial)

By signing this form, you acknowledge that you have been given the opportunity to read the clinic's Notice of Privacy Practices prior to any service being provided to you by this Practice, and you consent to the use and disclosure of your medical information to other healthcare providers involved in your care and for treatment, payment and healthcare operations. You have the right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH).

_____ _____ _____
Signature of Patient/Legal Representative | Print Name | Date

If Legal Representative, relationship to Patient:_____

Please notify receptionist if you want a copy of this signed form for your records.