Brandon Office
(Primary Mailing Address)
500 Vonderburg Drive
East Tower, Suite 102
Brandon, Florida 33511-5968

Sun City Center Office
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South Bay Medical Arts Bldg, Suite 112
Sun City Center, Florida 33573-6825

Cornerstone Medical Care

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Antonio V. Zumpano, M.D.
Julio A. Enriquez, M.D.
Pedro M. Enriquez, M.D.
Nordal Gonzalez Valera, M.D.
Shawna P. King, D.O.
Manuel A. Gomez, M.D.
Alessandra Cantone-Ferrill, M.D.

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Name: **Date of Birth:**

Former Name: **SSN:**

I request and authorize the facility listed above to release the requested healthcare information to:

[]Antonio V. Zumpano, MD []Julio A. Enriquez, MD []Pedro M. Enriquez, MD []Nordal Gonzalez Valera, MD
[]Shawna King, DO []Manuel A. Gomez, MD []Alessandra Cantone-Ferrill, MD []Melissa M. Schweitzer, FNP-BC
[]Nicole Q. Williams, FNP-C []Cathy S. Eaton-Hill, FNP-C []Ashley Newson, FNP-BC []Stela Karkatselos, FNP-BC
[]Danielle Harris, FNP-BC

Cornerstone Medical Care
500 Vonderburg Drive, Suite 102
Brandon, Florida 33511-5968
Fax: 813-681-5250

This request and authorization applies to:

[] Healthcare information relating to the following treatment, condition, or dates:

_____

[] All healthcare information

[] Other:

_____

Purpose:

[] Continuity of care, continuing healthcare treatment

[] Other reason (specify):

_____

[]**Yes** []**No** I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

[]**Yes** []**No** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Authorized Signature:_____ Date Signed: _____

If authorized signature is not patient's signature, specify relationship/or authority:_____

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.