Pinnacle
Health Services

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be written, dated, and signed by the patient or person authorized by law to give authorization.

I hereby consent and authorize the release of medical information for:

Patient Name: **Date of Birth:**

_____ _____

FROM:

_____

(Name of Clinic/Hospital, Address, Phone number and Fax number)

TO:

_____

(Name of Clinic/Hospital, Address, Phone number and Fax number)

By **INITIALING** the spaces below, I specifically authorize the release of the following medical records, if such exist.

_____ All hospital records (including nursing records and progress notes)

_____ Medical records needed for continuity of care _____ Pathology reports

_____ Emergency and urgency care records _____ Billing statements

_____ Clinical office chart notes _____ Other _____

_____ Diagnostic imaging reports (current films only; please do not send films over two years old.)

If the information to be disclosed contains any types of records or information listed below, additional laws relation to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **INITIALS** in the applicable space next to the type of information:

_____HIV/ AIDS information _____ Genetic testing _____ Mental Health Information

_____ Drug/ Alcohol diagnosis, treatment, or referral information.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

_____ _____

Signature of Patient Date Signature of Person Authorized by Law Date