



PINNACLE
HEALTHCARE SYSTEM



AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: _____

I hereby authorize you to release copies of my medical records and any information including the diagnosis and records of any treatment or examinations:

Related to or from the period of: _____

Please release the records to: (circle one)

PINNACLE HEALTHCARE SYSTEM

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DISCLAIMER: I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN COPIES OF INFORMATION RECEIVED FROM ANOTHER HEALTH CARE FACILITY OR DOCTOR AND ALSO AUTHORIZE THE RELEASE OF THIS INFORMATION TO THE INDIVIDUAL SPECIFIED ABOVE. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN REFERENCE TO OR THE RESULTS OF: HIV ANTIBODY (AIDS) TESTING, TESTING OR TREATMENT FOR COMMUNICABLE DISEASE, TREATMENT FOR MENTAL HEALTH PROBLEMS, TESTING FOR OR TREATMENT OF DRUG OR ALCOHOL ABUSE, AND I AUTHORIZE THIS INFORMATION.

Patient Name (Please Print)

Patient SS#

Signature of Patient

Patient Date of Birth

Relationship to Patient

Date