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

Hollywood Office
3700 Washington St, Ste 500
Hollywood, FL 33021
954-989-4700
Fax: 954-989-4754

Pembroke Pines
2213 N University Dr, Ste A
Pembroke Pines, FL 33024
954-963-2151
Fax: 954-966-6629

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 REFERRENCE 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