PINNACLE CARE
Internal Medicine

Authorization to Use, Disclose and Request Protected Health Information

There are times when Pinnacle Care Internal Internal Medicine will need to request reports and health information from your other physicians and/or medical centers for your care at Pinnacle Care Internal Medicine. We also keep your other physicians notified of your treatment outcomes by sending all treatment reports and information to their facilities. In order to do so, your authorization is required.

Patient Name (Last, First, MI): _____ Date of Birth: _____

Phone: _____ Address: _____

City: _____ State: _____ Zip Code: _____

I authorize the use, request and/or disclosure of my protected health information as described below. I understand that the information used or disclosed as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or disclosed to persons or organizations receiving it without obtaining my authorization. I have the right to revoke this Authorization by providing written notice to Pinnacle Care Internal Medicine. Revocation of the Authorization will not affect any action taken before the receipt of the written revocation. I release of the following information to: **Pinnacle Care Internal Medicine.**

Pinnacle Care Internal Medicine
9401 W. Thunderbird Rd., 155
Peoria, AZ 85381

I understand that this release is valid for the timeframe of my diagnoses through treatment, but I may revoke this authorization at any time by informing Pinnacle Care Internal Medicine and my physician.

Health Information to release includes the following (as checked):

- ☐ Records including consultation and follow-up notes
- ☐ Radiology reports, x-rays, operative notes, lab results
- ☐ Records from outside physicians that are sent to the physician at Pinnacle Care Internal Medicine.
- ☐ I give special permission to release any information regarding: (Initial on applicable line(s) only)
  _____ Substance Abuse _____ Genetic Testing _____ HIV Information

Purpose: (Check applicable categories)

- ☐ Further Medical Care
- ☐ Patients Request
- ☐ Insurance Eligibility/Benefits
- ☐ Disability Determination
- ☐ Legal Investigation
- ☐ Other:

Records to be Released: ☐ **From** ☐ **To**

Clinic Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Expiration Date and Other Information:
This authorization will expire after the completion of my treatment at Pinnacle Care Internal Medicine. A photocopy of this authorization is as valid as the original. I understand this authorization is voluntary . I am confirming my authorization the the health care provider may use, request and/or disclose to the persons and/or organizations named in this form the protected health information described above. I understand the no person or entity authorized to use, disclose or request health care information may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Patient Signature: _____ **Date:** _____

Updated 12/29/2018