

I hereby authorize Pinnacle Medical Group, Inc. to **disclose** or **receive** the following information from the health records of the patient listed below:

PRINT CLEARLY:

SECTION A PATIENT DATA	Patient Name:		SSN:
	Phone #:		Date of Birth:
SECTION B RELEASE FROM / TO	Release Information To:		Receive Information From:
	Person/Organization:		Person/Organization:
	Address:		Address:
	City/State/Zip:		City/State/Zip:
	Phone #: Fax#:		Phone #: Fax#:
SECTION D RELEASE DATA	Purpose of Disclosure: <input type="checkbox"/> Personal Access <input type="checkbox"/> Continued Care <input type="checkbox"/> Other (Describe)		
	<i>A separate authorization is required to authorize the disclosure or use of psychotherapy notes and HIV test results.</i>		
	The type of records and the dates of service to be released or disclosed is as follows (✓) check all that apply:		
	<input type="checkbox"/> Entire record (including Alcohol/drug treatment information) <input type="checkbox"/> Entire record (excluding Alcohol/drug treatment information) <input type="checkbox"/> Billing information <input type="checkbox"/> Problem list <input type="checkbox"/> Medication list <input type="checkbox"/> Immunization records <input type="checkbox"/> Laboratory results <input type="checkbox"/> X-ray reports <input type="checkbox"/> Mental health records (excluding psychotherapy notes) <input type="checkbox"/> Other diagnostic (specify) _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Limitation of release _____		
Date(s) of Service _____			
I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.			

**SECTION F
OFFICE USE ONLY**

Authorization Received by: _____ Date: _____
Patient/Representative Identification: _____ Verified by: _____
A copy of this authorization was offered/received by the patient.
Chart Location (✓): Fontana Rialto San Bernardino

**SECTION E
AUTHORIZATION**

I understand that information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not protected by California law and may no longer be protected by federal confidentiality law (HIPAA). The recipient of this information is requested not to re-disclose this information without my authorization for disclosure. **Pinnacle Medical Group, Inc.**, its employees, officers, and physicians are hereby released from any legal responsibility or liability for improper re-disclosure of the above information to the extent indicated and authorized herein.
A copy or photocopy of this authorization will serve the same validity as though an original had been presented.

YOUR RIGHTS
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
I may inspect or obtain a copy of the health information to be used or disclosed, as provided by 45 CFR 164.508(d)(1), (e)(2).
I have a right to receive a copy of this authorization.

**SECTION D
DURATION**

EXPIRATION
This authorization will automatically expire six months from the date of execution unless otherwise noted: _____

Signature of Patient or Legal Representative

Print Name

Relationship

Address/State/Zip (if other than patient)

Phone # (if other than patient)

Date Signed

Signature of Witness

Date
