Pinnacle™
HEALTH CARE

Authorization for Disclosure of Health Information

Patient Name: _____ Date of Birth:_____

Address: _____

_____

Phone #: _____

To: Provider: _____

Facility: _____

Address: _____

Phone/Fax: _____

If records requested exceed 20 pages please call 701-478-4722 before faxing.

- o By my signature below, I am authorizing Pinnacle Pediatric Clinic to **release** the following information to you and your facility:

  - O Progress Notes & WCC
    - O All
    - O From _____ to_____
  - O X-ray/Lab Reports
  - O Other Imaging Records
  - O Vaccine Record
  - O All Medical Records
  - O Other _____

- o By my signature below, I **request** that you provide copies of my medical record by fax or mail to Pinnacle Pediatric Clinic.

  - O Progress Notes & WCC
    - O All
    - O From _____ to_____
  - O X-ray/Lab Reports
  - O Other Imaging Records
  - O Vaccine Record
  - O All Medical Records
  - O Other _____

This authorization will remain valid for a period of one year from the date of signature, unless I revoke this decision in writing, which I may do at any time. I understand that my health information is protected, confidential and will be shared only with medical personnel as pertains to my medical care.

Patient Signature: _____ Date: _____
(parent or legal guardian if pt is under 18 years of age)

Witness: _____ Date: _____

_____

(Printed)