

Authorization for Use or Disclosure of Medical Record Information

MR#: _____ (for office use only)

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Work Phone: _____

Release Information To:

I hereby Authorize Pinnacle Radiology to release my medical record information to:

Mail Copies To: Hold for Patient Pick-up

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: Personal Continuing Care Legal Other: _____

Specific Information to be released:

Date(s) of Service: _____

Pertinent Information* (includes H & P, discharge and other dictated reports, EKG, labs and radiology)

Operative Report

Diagnostic Imaging Reports

Pathology Reports

Diagnostic Films (specify): _____

Complete Records: Date of Visit _____ Other (specify): _____

*Pertinent information is free of charge upon the first request. Additional requests for release of information will be charged \$9 per page. CD copies are \$5.00 each.

Authorization to Release Protected Information:

***Required** – Complete the check boxes below indicating how protected information should be handled even if the categories do not necessarily apply to the patient's medical records.

Check one

Initial each line to confirm choices

I DO/ I DO NOT want any/all of my radiology exams available to be sent to a medical specialist _____

I DO/ I DO NOT want information released to my family. List family members who are authorized

1. _____ 2. _____ 3. _____



Please confirm that you have put a checkmark and initialed all the protected information categories above regardless if they are applicable or not. If form is incomplete, we may be unable to fulfill this request.

My Rights:

I understand that this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization.

I understand that I may revoke this authorization at any time, with some exceptions, that being to the extent the hospital has acted on this authorization prior to the date we received the letter to revoke authorization.

To revoke my authorization, I must submit a written request to Pinnacle Radiology facility.

I am entitled to receive a copy of this Authorization.

Notice to Recipient:

This information has been disclosed to you from records whose confidentiality is protected by Federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information without express written consent of the person to whom it pertains. The information being release will no longer be protected from re-disclosure by recipient.

This authorization will expire within 1 (one) year unless I note here a specific date, event or condition.



Patient's Signature

Date

Parent/Legal Health Care Representative Signature*

Date

Released by

ID Used

Date

***A copy of any Power of Attorney must be provided, if requestor is the POA.**

Instructions for Submitting Form:

Completed forms can be mailed, faxed or delivered in person to the facility where you received services (Monday – Friday, 8:00 a.m. – 5 p.m.). **A photo ID* must be provided with form** (or provide legible copies for mailed/faxed requests).

*Accepted photo IDs include government-issued photo IDs and John C. Lincoln employee IDs.

Pinnacle Radiology Deer Valley

Attn: Health Information Department
19636 N. 27th Ave LL1
Phoenix, AZ 85027
Phone: 602-485-7482
Fax: 623-445-6410
Office hours: M – F, 8:00 a.m. – 5 p.m.

Pinnacle Radiology Tatum

Attn: Health Information Department
18404 N. Tatum Blvd #103
Phoenix, AZ 85032
Phone: 602-485-7482
Fax: 602-485-7497
Office hours: M – F, 8:00 a.m. – 5 p.m.

Pinnacle Radiology Anthem

Attn: Health Information Department
3648 W. Anthem Way #A100
Anthem, AZ 85086
Phone: 623-434-6474
Fax: 623-434-6441
Office hours: M-F, 8:00 a.m. – 5 p.m.