Pinnacle Psychiatry

17505 N 79th Avenue, Suite 407, Glendale, AZ 85308
623.321.2221 (office) 855.397.2676 (fax)

Release of Information

Patient Name:_____Date of Birth:_____

I grant permission for Pinnacle to discuss and/or release my medical records and/or information to:

Name of Person, Provider or Practice:_____

Relationship to Patient: _____

Phone:_____Fax:_____

Email:_____

I authorize TWO-WAY communication in print, fax, email, telephone, or in person between Pinnacle Psychiatry and the aforementioned provider, practice, or person, to facilitate transfer of my comprehensive medical record for the purpose of continuity or transfer of my care, or ensuring optimal outside information is obtained regarding the patient. Unless noted as indefinite, this release is valid for one full year from the date signed.

I understand that I may revoke this authorization at any time, unless the disclosing party has already exercised this release to obtain or disclose health information. To revoke my authorization, I must submit a written request to Pinnacle Psychiatry.

I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by the person/organization that receives the information.

I release the practice, its personnel, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____

Patient or Legal Guardian Signature Date

If you are not the patient, but are signing on behalf of the patient, please attach legal documentation verifying guardianship.