Pinnacle Psychiatry

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

Request for Records

Patient Name:_____Date of Birth:_____

Requesting Records From:_____

Phone:_____ Fax:_____

PLEASE SEND COMPREHENSIVE EXISTING MEDICAL RECORDS FOR THE ABOVE PATIENT TO:

Pinnacle Psychiatry, PLLC
17505 N 79th Ave, Suite 407
Glendale, AZ 85308
PHONE: 623.321.2221
FAX: 855.397.2676
EMAIL: FrontDesk@PinnaclePsych.com
(This email is HIPAA compliant)

*****PLEASE SEND RECORDS THROUGH WHATEVER MEDIUM IS MOST EXPEDIENT, TO FACILITATE URGENT PSYCHIATRIC CARE.*****

I authorize two-way communication in print, fax, email, telephone, or in person between Pinnacle Psychiatry and the aforementioned provider or practice to facilitate transfer of my comprehensive medical record for the purpose of continuity or transfer of my care. 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.