PINNACLE ORTHOPAEDICS AND SPORTS MEDICINE
Patient Authorization for Release of Health Information

Patient Name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Check One:
☐ **I request that my Patient Health Information (PHI) from Pinnacle Orthopaedic and Sports Medicine be disclosed to:**

Recipient Name: _____

Mail to Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Or Fax to : _____

☐ **I request that _____ release my Patient Health Information (PHI) to Pinnacle Orthopaedic and Sports Medicine: (See Disclosure Format below) Mail to 300 Tower Road, Suite 200, Marietta, Ga. 30060 Attn: Medical Records, Or Fax to (770) 429-7778**

I authorize the following PHI to be released from my medical record(s) as outlined above: (circle)

Complete Records Operative Reports Progress Notes X-Rays Labs

Treatment Records Hospital Reports Other (Please Specify) _____

Specific Date(s): _____ to _____ OR ☐ All past, present and future encounters/visits

Purpose for requesting information: ☐ Legal ☐ Insurance ☐ Personal Continuation of Care

Other: _____

Disclosure Format (Paper is default if not marked.): ☐ US Mail – paper format ☐ Fax

☐ CD/Flash drive – secure format ☐ Patient Pick-Up Date: _____ ☐ Other: _____

I understand that the information in my health record may include information relating to sexually transmitted disease (STD), Acquired Immunodeficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and federal law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records □ Yes □ No Dates: _____
HIV Testing and Results □ Yes □ No Dates: _____
Mental Health □ Yes □ No Dates: _____
Psychotherapy Records □ Yes □ No Dates: _____

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to the Health Information Management Department at the following address: 300 Tower Rd, Suite 200, Marietta, Ga. 30060. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will expire on the following date/event/condition: _____. If I fail to specify an expiration date/event/condition, this authorization will expire *one year* from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected

one year from the date signed.

- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Print Name and/or Name and Relationship to Patient (if applicable)	**Patient Acct#**
Patient or Authorized Representative Signature	**Signature Date**

(Revised 01/19/2016)