PINNACLE INTERVENTIONAL
PAIN & SPINE CONSULTANTS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____
(Last) (First) (M.I.)

Date of Birth: _____ Social Security #: _____

I request and authorize Pinnacle Interventional Pain & Spine Consultants to release healthcare information of the above named patient to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applies to:

- Healthcare information relating to the following treatment, condition or dates: _____

  _____
- All healthcare information
- Other: _____

  _____

I understand and hereby also consent to the release of any and all alcohol and/or drug abuse information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) or psychiatric treatment records under the same conditions outlined below. I also understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected. My failure to sign this authorization may result in my information not being released.

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one year.

I understand per Ohio law there may be charges for the copying and release of information and accept financial responsibility.

X _____ ____ / ____ / _____
Signature of Patient/Legal Representative* Date Signed

_____ ☐ Patient unable to sign
Description of Legal Representative's Authority to Act on Behalf of Patient (if applicable)

* If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented, the exception is a parent of minors under 18 years of age.