**HIPAA Release of Medical Information Form**

\*\*Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)\*\*

\*\*1. Authorization\*\*  I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (healthcare provider) to disclose the protected health information described below to □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ **Pinnacle Pediatrics and Internal Medicine. A: 13648 Orchard Parkway, Suite 900, Westminster, CO, 80023. P: 720-239-7725. F: 720-239-7730. E: careteam@pinnaclepedim.com**

\*\*2. Effective Period\*\*  This authorization for release of information covers the period of healthcare from: a. □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_. \*\*OR\*\* b. □ all past, present, and future periods.

\*\*3. Extent of Authorization\*\* a. □ I authorize the release of my complete health record (including records  relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of  alcohol or drug abuse). \*\*OR\*\* b. □ I authorize the release of my complete health record with the exception  of the following information: □ Mental health records □ Communicable diseases (including HIV and AIDS) □ Alcohol/drug abuse treatment □ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. This medical information may be used by the person I authorize to receive  this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and in effect for 90 days after signing, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing,  at any time. I understand that a revocation is not effective to the extent that any  person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the  insurer has a legal right to contest a claim. 7. I understand that my treatment, payment, enrollment, or eligibility for  benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this  authorization may be disclosed by the recipient and may no longer be protected by  federal or state law.

Patient Name(s) & DOB(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_