PINNACLE
RHEUMATOLOGY

Authorization for Use or Disclosure of Health Records

Print Name of Patient: _____

Today's Date_____

Birthdate:_____ SSN: _____

My Authorization

I authorize the following using or disclosing party: _____to use or disclose the following treatment or condition.

- o All of my health information
- o Last two office visits, last two labs and last DEXA scan
- o My health information relating to the following treatment or condition:

  _____

The above party may disclose this health information to the following recipients: Pinnacle

Rheumatology

9300 E. Raintree Dr. Ste 130, Scottsdale, AZ 95260

Fax: (480)770-4093. Email: info@pinnaclerheumatology.com

The purpose of this authorization is at my request.

This authorization ends: Date _____

My Rights

I understand that I have the right to revoke this authorization in writing at any time, except when action has already been taken.

I understand that disclosures already made based upon my permission cannot be taken back.

I understand that information disclosed with my permission may be re-disclosed and is no longer protected by HIPAA standards.

I understand that treatment cannot be conditioned on signing this authorization (unless solely for creating health information for a third party or for research).

I will receive a copy of this authorization after signing. A copy is as valid as the original.

Signature of Patient: _____Date: _____