PINNACLE
COLON AND RECTAL SURGEONS
Colon and Rectal Surgery and Colonoscopy
An Affiliate of Arizona Oncology

1. PATIENT IDENTIFYING INFORMATION:

Patient Name: ____ Date of Birth: ___________________________

Address: ____ City ___________ State __________ Zip Code: ___________

Phone Number: ______________________ Date(s) of Service(s): ____

A. Release of medical records:

I authorize ____________________________ to release my medical records as I have indicated in ***Section 2*** below:

Disclose to: ____

Address: ____

Phone Number: _____________________________ Fax Number: __________________________________

2. **SPECIFIC DESCRIPTION OF INFORMATION TO BE DISCLOSED** (check all that apply): _____ Entire Record

______ Discharge Summary ______ History and Physical Exam ______ Operative Reports _____ EKG
______ X-Ray Reports ______ Lab Tests ______ Consultations ______ Pertinent Records Only Other (Specify) ____

Specific description of the purpose of the disclosure:
______ Continued Patient Care ______ Worker's Comp _______ Insurance/Payment of Care
______ The disclosure is at the patient's request Other (Specify) ____

I authorize the provider to use or disclose information related to:
______ AIDS/HIV _______ Genetic Testing Information
______ Psychiatric Care Reports _______ Alcohol and/or Drug Abuse Treatment

____ ____
Signature of Patient Date

____ ____
Signature of Legal Representative Relationship to Patient or Description OR Authority to Act for Patient