Release of Medical Information

Please send records to:

Pinnacle Health Center
Priti Modi MD
1608 Tully Road
Modesto, CA 95350
Ph: 209-409-8589 Fax: 209-409-8691

I, _____, with a date of birth, _____, give my permission for
(Patient name) (Patient's DOB)

Requesting records from:

Name of Practice: _____

Name of Physician: _____

Fax number: _____

Address: _____

I understand that:

- **I do not have to give my permission to share these records.**
- **If I want to take away the permission for my doctor to get these records, I need to talk to my doctor or a staff person and sign a paper.**
- **This form is only good for 3 months from the date I sign it.**

Patient's Signature _____ Date _____

Authorized Representative's Signature _____ Date _____

Relationship of Authorized Representative _____