



AUTHORIZATION FOR RELEASE OF PATIENT IDENTIFIABLE HEALTH INFORMATION

To: Peninsula Imaging, LLC
1655 Woodbrooke Drive
Suite 101
Salisbury, MD 21804

I am requesting and authorizing you to release and furnish medical records and information to:

_____ (name of person, physician or facility)

_____ (address, phone and fax)

The requested records are to be mailed / picked up. (please specify)

The requested records and information pertains to:

Name: _____
Address: _____
D.O.B.: _____
MRN: _____

This authorization is limited to the following records and information:

- All patient exams
- Bone density
- CT Scan
- Mammogram
- Pet Scan
- MRI
- Ultrasound
- X-Ray
- Reports
- Relocating/Not returning
- Report to Fax: _____ (fax number)

Signature: _____

Today's Date: _____

Printed name and relationship of person signing on behalf of patient

I understand that the information in my health record may include information about my history, diagnoses and / or treatment. I authorize the disclosure of this specific information listed above. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy law or regulations may not protect information. Your signature allows us to release medical information to the parties designated above for one year.