



1655 Woodbrooke Drive  
Salisbury, MD 21804  
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**AUTHORIZATION FOR RELEASE OF PATIENT IDENTIFIABLE HEALTH INFORMATION**

I am requesting and authorizing Peninsula Imaging to release/receive medical records and information to/from:

\_\_\_\_\_  
(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.