Peninsula Imaging L.L.C.

1655 Woodbrooke Dr
Salisbury, MD 21804
Telephone: 410-749-1123
Fax: 410-543-1063

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:

- o All patient exams
- o Bone density
- o CT Scan
- o Mammogram
- o Pet Scan
- o 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.