

**PENINSULA REGIONAL MEDICAL CENTER  
AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**THERE IS A STANDARD CHARGE FOR ALL MEDICAL INFORMATION NOT INTENDED FOR CONTINUED PATIENT CARE. For more information, please consult a Customer Service Representative in Health Information Management.**  
Health Information Management Department 100 East Carroll Street Salisbury, MD 21801 ■ Phone 410-543-7075  
**Fax the completed form to 410-912-5794 or email to inforelease@peninsula.org**

Social Security Number (last 4 digits): \_\_\_\_\_ Today's Date: \_\_\_\_\_

I, the undersigned, hereby authorize Peninsula Regional Medical Center to release copies of protected health information (PHI) on

Name: \_\_\_\_\_ Date of Service: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If mailed send to: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

The purpose or need for such disclosure is \_\_\_\_\_

The medical records to be released may contain information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment.

Peninsula Regional Medical Center is authorized to release/request the following medical reports (please check desired information to be sent):

- |  |  |
|--|--|
| <input type="checkbox"/> Outpatient Surgery    | <input type="checkbox"/> Admission History and Physical        |
| <input type="checkbox"/> Emergency Room Record | <input type="checkbox"/> Discharge Summary                     |
| <input type="checkbox"/> X-Ray, EKG, EEG, Labs | <input type="checkbox"/> Operative Report and Pathology Report |
| <input type="checkbox"/> Pulmonary Function    | <input type="checkbox"/> Consultation Report                   |
| <input type="checkbox"/> Physical Medicine     | <input type="checkbox"/> Clinic                                |
| <input type="checkbox"/> Nuclear Medicine      | <input type="checkbox"/> Other (specify): _____                |

MyPencare (Patient Portal) access: \_\_\_\_\_  
Patient's email address required

This information has been disclosed from records protected by various federal confidentiality rules and regulations. These federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by written authorization of the person to whom it pertains or as otherwise permitted by federal confidentiality rules and regulations. A general consent for the release of medical or other information is NOT sufficient for this purpose. Federal rules and regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that the information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by this rule.

I hereby authorize \_\_\_\_\_ to pick up the fore-mentioned Protected Health Information (PHI).

\_\_\_\_\_  
Patient Signature/Representative

This authorization will expire in one (1) year. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Peninsula Regional Medical Center in reliance on this authorization, by sending a written revocation to, Privacy Officer, Peninsula Regional Medical Center, 100 East Carroll Street, Salisbury MD 21801.

\_\_\_\_\_  
Patient Signature / Representative Date/Time Relationship

\_\_\_\_\_  
Street Address Witness Date/Time

\_\_\_\_\_  
City, State, Zip Telephone Number

