PENINSULA REGIONAL MEDICAL CENTER
AUTHORIZATION TO RELEASE
MEDICAL INFORMATION

Phone: 410-543-7075 Fax: 410-912-5794
Email: inforelease@peninsula.org

PATIENT INFORMATION:
Name: _____
Date of Birth:_____

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

RECIPIENT:
Name: _____
Address: _____
_____
City: _____
State: _____Zip Code:_____
Phone #:_____
Email:_____

PURPOSE FOR DISCLOSURE:
_____
_____
_____
_____

☐ Check box if disclosure is at the request of patient or authorized representative

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

[ ] Entire medical record [ ] Dates(s) of Service: _____
[ ] Only the following items from my medical record (check all that apply):
[ ] Outpatient Surgery [ ] Admission History and Physical [ ] Physical Medicine
[ ] Emergency Room Record [ ] Discharge Summary [ ] Nuclear Medicine
[ ] X-Ray, EKG, EEG, Labs [ ] Clinic [ ] Consultation Report
[ ] Pulmonary Function [ ] Operative Report and Pathology Report
[ ] Other specify):_____
[ ] MyPenCare (Patient Portal) access: _____
Patient's email address required

I authorize Peninsula Regional Medical Center to include the following information in the records released (unless I have checked the following boxes, the information described below will NOT be released):

[ ] Mental Health records [ ] Drug and/or Alcohol dependency treatment records [ ] HIV/AIDS test results
[ ] Medical records received from another health care provider

Medical records received from other health care providers will not be released if re-disclosure is prohibited by that provider.

I understand that once my information is disclosed to the Recipient that the information disclosed pursuant to this authorization may be subject to redisclosure by the Recipient and no longer protected by federal privacy or security laws.
Peninsula Regional Medical Center may not condition treatment, payment, enrollment or eligibility for benefits on providing or refusing to provide this Authorization. unless: (a) this Authorization is for clinical research, in which case Peninsula Regional Medical Center may condition the research-related treatment on providing this Authorization; or (b) the health care provided by Peninsula Regional Medical Center is solely for the purpose of creating health information for disclosure to a third party (such as an employment physical), in which case Peninsula Regional Medical Center may condition the provision of such health care on providing this Authorization.
This authorization will expire in one (1) year. I understand I may revoke this authorization in writing at any time by sending a written revocation to Privacy Officer, Peninsula Regional Medical Center, 100 E. Carroll Street, Salisbury MD 21801.

_____
Signature Patient/ Representative

_____
Street Address

_____
City, State, Zip

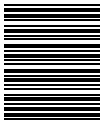
_____ _____
Date signed Telephone Number

_____
Relationship of Representative

_____
Representative Printed Name

_____
Describe Representative's Authority to Act for Patient (if signing as a legal representative, please provide documentation to support status)

A COPY OF THIS AUTHORIZATION MUST BE GIVEN TO THE PATIENT/REPRESENTATIVE
NOTE: standard fees may apply as allowed by law



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