REGIONAL MEDICAL CENTER
AUTHORIZATION TO RELEASE MEDICAL INFORMATIC

FOR ALL MEDICAL INFORMATION NOT INTENDED FOR CONTINUED PATIENT CARE, there is a standard charge. For mort information, please consult a Customer Service Representative in the Medical Information Department.

Social Security Number: _____ Today's Date: _____

I, the undersigned, hereby authorize 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):

[ ] Outpatient Surgery
[ ] Emergency Room Record
[ ] X-Ray, EKG, EEG, Labs
[ ] Pulmonary Function
[ ] Physical Medicine
[ ] Nuclear Medicine
[ ] Admission History and Physical
[ ] Discharge Summary
[ ] Operative Report and Pathology Report
[ ] Consultation Report
[ ] Clinic
[ ] Other _____
specify

This information has been disclosed from records protected by various federal confidentially 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

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.

This authorization will expire one (1) year from date unless otherwise specified: _____

_____ _____
Patient Signature / Representative *Relationship*

_____ _____
Street Address *Witness*

_____ _____
City, State, Zip *Telephone Number*

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