

PENINSULA CARDIOLOGY ASSOCIATES, P.A.
AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

Today's Date: _____

PATIENT INFORMATION:

Name: _____
Address: _____

SSN: _____
Date of Birth: _____

AUTHORIZATION FOR RELEASE: I hereby authorize **Peninsula Cardiology Associates, P.A.** of 400 Eastern Shore Drive, Salisbury, MD 21804, to release, disclose, and deliver the confidential information described below to:

AUTHORIZED RECIPIENT:

Name: _____
Address: _____

Tel/Fax: _____

NATURE OF INFORMATION TO BE RELEASED:

- | | | |
|----------------------------------------------------|--------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Lab Reports | <input type="checkbox"/> Consultation Reports |
| <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> ER Reports |
| <input type="checkbox"/> Diagnostic Studies | <input type="checkbox"/> All | <input type="checkbox"/> Other: _____ |

The medical records to be released may contain medical information pertaining to drug and/or alcohol abuse, psychological or psychiatric impairment, Acquired Immunodeficiency Syndrome (AIDS) or test for, or infection with Human Immunodeficiency Virus (HIV).

This authorization is confined to the following dates of treatment: From: ___/___/___ To: ___/___/03.

The requested records will be used for: _____.

It is my intent that information furnished is prohibited for any purpose other than that stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above. I further direct that only information prior to the date of my signature below be honored; that this request be transmitted to you within 90 days of my signature below; and that a photocopy of this authorization be granted the same authority as the original.

I further hereby release Peninsula Cardiology Associates, P.A. and you personally from all legal responsibility and/or liability that may arise from the release of such records as specified above, and hereby waive all rights I have to preserve their confidentiality. I understand that this consent can be REVOKED in writing at any time except to the extent that disclosure has already occurred in reliance on this consent. I further understand that this consent will expire ninety (90) days from the date signed and that a fee for preparing and furnishing this information may be charged, if information not intended for continuity of patient care. I have read and understand all information contained herein.

Patient Signature/Representative

Date

Relationship

Witness

Date