Peninsula Imaging

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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
- o Ultrasound
- o X-Ray
- o Reports
- o Relocating/Not returning
- o Report to Fax: _____ (fax number)
- o Email

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.

By signing below, you understand and acknowledge that sending protected health information electronically in an unsecured method is not advisable and therefore you agree to not hold Peninsula Imaging responsible for any potential electronic breach of information that may occur by sending the medical records using your preferred method.

Signature: _____ Today's Date: _____

_____
Printed name and relationship of person signing on behalf of patient