Elizabeth Pernal MD PA
813 A Eastern Shore Drive
Salisbury MD 21804
(410) 860-5151
Fax: (410) 860-2026

AUTHORIZATION TO RELEASE MEDICAL RECORDS FROM ELIZABETH PERNAL MD PA

Patient Name: ____ DOB: __________________

Address: ____

____

Phone #:_______________________

Please release my medical records from Elizabeth Pernal MD PA to:

PLEASE INCLUDE A FAX NUMBER

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Information to be released:

( ) Last seven (7) years.

( ) Less than seven (7) between the following dates:

_______________________ and ________________________.

Purpose: ____

I may revoke this authorization in writing at any time (except to the extent that action has already been taken in reliance upon it). Unless revoked or renewed this authorization will expire on _________________. If an expiration date is not specified, this authorization will expire in one (1) year from the date signed.

I understand that my medical record (in whole or in parts) may contain information about alcohol and substance use/abuse, psychiatric or psychological problems, HIV*, AIDS, sexually transmitted diseases, pregnancies, genetic testing and other sensitive information. * Human Immunodeficiency Virus that causes AIDS

I authorize the release of my medical records as specified above. Medical records will only be sent by fax or may be picked up at our office. I understand I may be charged a fee.

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Recipient (if picked up) Date