Elizabeth Pernal MD PA
813 A Eastern Shore Drive
Salisbury MD 21804
(410) 860-5151
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AUTHORIZATION TO RELEASE MEDICAL RECORDS TO ELIZABETH PERNAL MD PA

Patient Name: _____ DOB: _____

Address: _____ SS#: _____

_____

Phone # (day):_____ Phone # (night):_____

Please release my medical records **from**:

_____

_____

_____

to Elizabeth Pernal MD PA.

Information to be released:

( ) Entire medical record.

( ) All of my medical records concerning treatment you have provided for the specific condition(s) as follows: _____.

( ) All medical records concerning treatment provided 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.

I authorize the release of my medical records as specified above.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

* Human Immunodeficiency Virus that causes AIDS