BioImaging
MRI Center

528 Madison St, Huntsville, AL 35801

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

NAME OF PATIENT: _____

PATIENT DOB:_____ PATIENT SSN:_____

DATE OF PROCEDURE: _____

PURPOSE OF RELEASE: _____

NAME AND ADDRESS OF PARTY INFORMATION IS BEING RELEASED TO:

_____

_____

I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL MEDICAL INFORMATION RELATING TO THE IMAGING PROCEDURE RECEIVED BY THE ABOVE NAMED PERSON 0N AND SUBSEQUENT TO THE DATE THE PROCEDURE WAS PERFORMED. AUTHORIZATION EXPIRES IN 365 DAYS UNLESS REVOKED IN WRITING.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

_____

DATE

_____

WITNESS

_____

DATE

_____