

MEDICAL RECORDS RELEASE AUTHORIZATION

Please provide us with the following information:

Patient's Name:	Telephone Number:
Address:	
Social Security Number:	Date of Birth:

SECTION A: For the purpose of: Exam Comparison

I hereby authorize Florida Radiology Leasing, LLC and its physicians, employees and agents and its representatives to obtain my medical records for the purpose listed above.

Records Needed: MRI Ultrasound X-Ray/Fluoro Nuc Med CT

Release to the following location:(Check one)

- | | | |
|--|--|---|
| <input type="checkbox"/> South Pointe Location
6311 South Pointe Blvd.
Ste. 600
Fort Myers, FL 33919 | <input type="checkbox"/> Barkley Circle Location
63 Barkley Circle
Ste. 100 & 101
Fort Myers, FL 33907 | <input type="checkbox"/> Medical Records Main Office
2726 Swamp Cabbage Court
Fort Myers, FL † |
|--|--|---|

SECTION B: For the purpose of the Requested Use or Disclosure (check one)

- Self/Authorized Rep
 Other Medical Office _____

Please check below the specific protected health information you are authorizing be used and/or disclosed: Films Report Films/Report CD

MRI Nuclear Medicine Ultrasound X-Ray/Fluoro CT

SECTION C: Authorization Timeframe

This authorization is valid for a period of: (check one)

Month 6-Months 1-year

Patient's Name Signature: _____ Date: ____/____/____

SECTION D: Authorized Personal Representative

I further authorize you to provide to and discuss with _____
(Authorized Personal Representative) any confidential information with respect to my medical condition or treatment, either formally or informally. This authorization is voluntary and I have the right to revoke my authorization at any time with written notice to Florida Radiology Leasing, LLC.

Patient's Name Signature: _____ Date: ____/____/____