PREMIER WOMEN'S RADIOLOGY
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CONSENT AND AUTHORIZATION FOR RELEASE OF RECORDS

ATTENTION: Medical Records Dept.

Patient Name:_____ Date of Birth:_____

Social Security No.:_____

AUTHORIZATION IS HEREBY GRANTED TO RELEASE MEDICAL INFORMATION FROM:

_____

_____

_____

_____

_____ Provide reports and CD copies of diagnostic imaging _____ Approx. Dates

FOR THE PURPOSE OF: Continuity of Care and improved sensitivity of examination

I understand that I may revoke this consent to release information at any time. I also understand that my release shall not constitute a breach of my right to confidentiality. This authorization expires 90 days from the date below.

I understand that the information released cannot be redisclosed by person(s), institutions(s) named above unless I specifically authorize such a release in writing.

_____ _____
Patient or Representative Signature Date

Authorization must be signed by the patient. If the patient is under 18 years of age, or is not legally competent, or is unable to sign, the parent or designated legal representative must provide authorization.

Completed By Guardian:_____ _____
Date