6300 St. Johns Ave
Palatka, FL 32177
P: 386-280-0080
F:386-280-0081

Authorization for Release of Information

I, _____, hereby authorize Express Medical Imaging to release / obtain the medical information about me indicated below to / from the following entity / individual.

☐ Release ☐ Obtain

Entity / Individual:	Address:
Phone & Fax:	City, State, Zip Code:

Records Needed: ☐ Reports ☐ Images ☐ Reports and Images

☐ Radiology Images ☐ Magnetic Resonance Imaging (MRI) Images ☐ Ultrasound

☐ CT Scan ☐ Mammogram ☐ Other:_____

Dates of Service:

☐ All ☐ Last Visit Only ☐ From: _____ To: _____

☐ Other:_____

This information is requested for the purpose of: _____

_____

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any information already released under this Authorization. I understand that I am under no obligation to sign this Authorization. I understand that I have a right to receive a copy of this Authorization.

Patient's Name:_____ Date of Birth:_____

Patient or Parent/Guardian Signature: _____ Date: _____