AUTHORIZATION FOR RECORDS RELEASE

Patient:

MRN:

DOB:

Sex:

S.S.N:

DATE:

To: (Doctor/Hospital)

Attn:

Phone: Fax:

I hereby authorize the release of my previous imaging studies, records or copies of such and request that they are sent to:

Palm Harbor MRI
32615 US Hwy 19 N Ste 4
Palm Harbor, FL 34684
Phone: 727-787-6900
Fax: 727-787-1892

Records Requested:

Print Name of Patient:

Patient's Signature: **Date:**