



**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PROVIDER'S (FACILITY) NAME: \_\_\_\_\_

PROVIDER'S (FACILITY) ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

REQUESTER'S NAME: INSTITUTE OF DIAGNOSTIC IMAGING  
REQUESTER'S ADDRESS: 424 RACETRACK ROAD, N.W. PH: (850) 314-7575  
FORT WALTON BEACH, FL 32547 FAX: (850)314-7494

**DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED**

RADIOLOGY EXAMS AND REPORTS  CAT SCAN EXAMS AND REPORTS  
SPECIFY FILM (S) / DATE (S) SPECIFY FILM(S) / DATE(S)

MRI EXAMS AND REPORTS  NUC. MEDICINE EXAMS AND REPORTS  
SPECIFY FILM(S) / DATE(S) SPECIFY FILM(S) / DATE(S)

ULTRA SOUND EXAMS AND REPORTS  MAMMOGRAPHY EXAMS AND REPORTS  
SPECIFY FILM(S) / DATE(S) ALL EXAMS

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND THAT IT IS STRICTLY VOLUNTARY. **FILMS MAY NOT BE RELEASED W/O SIGNATURE.**
2. IF I DO NOT SIGN THIS FORM, MY HEALTH CARE AND THE PAYMENT FOR MY HEALTH CARE WILL NOT BE AFFECTED UNLESS STATED OTHERWISE.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING, BUT IF I DO, IT WILL NOT AFFECT ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. I UNDERSTAND THAT I MAY SEE AND OBTAIN A COPY OF THE INFORMATION DESCRIBED ON THIS FORM, FOR A REASONABLE COPY FEE, IF REQUESTED.
5. I CAN RECEIVE A COPY OF THIS FORM AFTER I SIGN IT, IF REQUESTED.

I HAVE READ THE ABOVE AND AUTHORIZE THE DISCLOSURE OF THE PROTECTED HEALTH INFORMATION.

SIGNATURE OF PATIENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME OF PATIENT/GUARDIAN: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_