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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:

Images 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. In 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.

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Patient's Name:____ Date of Birth:______________________

Address: ____

Patient or Parent/Guardian Signature: ________________________________ Date: _______________________