EXPRESS MEDICAL IMAGING CENTER

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ _____

I request and authorize _____

(Name of previous facility where you had mammogram done)

To release healthcare information of the patient named above to:

Express Medical Imaging Center
6300 St Johns Ave
Palatka Fl 32177
Phone (386)280-0080 Fax (386)280-0081

This request and authorization applies to:

- ❑ Healthcare information relating to the Following treatment, condition, or dates: **Mammography DVD and Reports** _____
- ❑ Other: _____

Patient Signature: _____ Date: _____

For Internal Use Only:

Faxed Date: _____ Received Date: _____ Appt Scheduled: _____