AUTHORIZATION FOR RELEASE OF FILMS/REPORTS

Patient Name: _____ DOB: _____

Doctor/Facility/Person Authorized to Receive Films/Reports:

_____

Address: _____

_____

FILMS/REPORTS TAKEN:

CT SCANS	_____	OUTSIDE FILMS	_____
MAMMOGRAMS	_____	ULTRASOUND	_____
MRI	_____	X-RAYS	_____
CD	_____		

I DO HEREBY RELEASE SDI DIAGNOSTIC IMAGING CENTER, of all responsibility in case of theft, loss or damage to these films. I accept full responsibility for the films, records or reports I have received. I understand that the films provided are the originals and SDI will not be able to provide copies beyond this transaction.

_____ _____
Signature of Patient Date

NOTE: Patient must present a valid state or federal issue photo identification with this authorization. If submitting this form via fax, please include a photo copy of a valid photo ID.

Please FAX this completed form to: 813-348-6999

This section to be completed at time records are picked up.

Name of Patient/Authorized Person Receiving Records: _____

Signature of Authorized Person (if different from Patient): _____

Photo ID Verified by (SDI Initials): _____