USMD Imaging Centers

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, hereby authorize
(Name of patient or legal representative)

USMD Diagnostic Services LLC, to disclose the following information by ☐ mail ☐ email ☐ fax ☐ orally to:

Name: _____
(Name of person/entity who should receive records)

Address: _____
(Address of person/entity who should receive records)

City, State, Zip Code: _____

Phone Number: _____ Fax Number: _____

Email address: _____
(Email address of person/entity who should be receiving the imaging films.)

Name of Patient: _____ Date of Birth: _____
(Last) (First) (Middle initial)

For the purpose of: _____

My authorization extends only to those data elements/documents marked below:

Date of imaging exam: _____

☐ Mammogram ☐ MRI/CT ☐ Ultrasound ☐ Bone Density ☐ X-Ray

☐ Other (must be specific below):

_____

This authorization is given freely with the understanding that:

1. A photocopy or fax of this authorization is as valid as this original.
2. I may revoke this authorization at any time in writing, except where information has already been released.
3. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
4. Treatment, payment, enrollment, or eligibility of benefits may not be conditioned on obtaining this authorization.

_____ _____
Patient/Legal representative signature Date

_____ _____
Relationship to patient Expiration date of authorization
unless otherwise noted, authorization expires 1 year from date of signature