IMI
INVERNESS MEDICAL IMAGING

Inverness Medical Imaging Authorization to Release Diagnostic Imaging Records

I hereby authorize the release of my records from the below agency/facility/physician(s) to Inverness Medical Imaging (IMI):

Agency/Facility/Physician(s) Name(s):_____

Address:_____ City/State:_____

Patient Name:

_____

Last First Middle Maiden (previous)

_____

Date of Birth Social Security#(last 4)

Date:_____

Information is to be disclosed to:

Inverness Medical Imaging
2105 Hwy 44 West
Inverness, Fl 34453
Phone#: (352) 637-6100
Fax#: (352) 637-6900

For the Purpose of: Comparison purposes

Information to be disclosed shall include:_____

☐ Reports
☐ Diagnostic Imaging Studies (Films or CD)

Affirmation of Release: I hereby authorize the above-named agency/facility/physician(s) with permission to release the information I have selected on this form to Inverness Medical Imaging (IMI). I understand that this authorization will expire two years from the date it was signed. I may refuse to sign this authorization or may revoke this authorization at any time. I understand that if I do revoke this authorization, revocation will take effect on the date it is received in writing. I understand that if I do refuse to sign this authorization, IMI cannot retrieve previous studies for comparison purposes, and I release IMI of any liability.

Patient/Guardian/Legal Representative Signature: X_____