RELEASE OF MEDICAL RECORDS

Inverness Medical Imaging
A Community Imaging Alliance Location
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I authorize the release of my confidential protected health information to Inverness Medical Imaging and/or affiliates, to include my entire medical record and more specifically radiology reports and images as described and listed below:

BREAST RELATED IMAGING

Requested Images via CD and Reports

I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that the information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient.

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

Patient Name (please print)	**Date of Birth**
Other Names Used	**Phone Number**
Patient Signature	**Date Signed**

NAME/ADDRESS OF FACILITY:

_____ **Phone Number:** _____

_____ **Fax Number:** _____

_____

Date/Time Faxed:	**Faxed By:**

Note: The information contained in this facsimile may be privileged and confidential and protected from disclosure. If the reader of this facsimile is not the intended recipient you are hereby notified that any reading, dissemination, distribution, copying, or other use of this facsimile is strictly prohibited. If you have received this facsimile in error please notify the sender immediately by telephone at (352) 637-6100 ext. 2480 or 2481.