FLORIDA HOSPITAL
MEMORIAL MEDICAL CENTER
Imaging

Florida Hospital Imaging
335 Clyde Morris Blvd #250
Ormond Beach, FL 32174
Phone: (386) 671-4780 FAX: (386) 671-9494

Medical Records Release Form

PATIENT NAME: _____DOB:_____

Previous Names: _____SS#:_____

Address: _____

Phone:_____(home) _____(cell)

Requested From:

Name of Facility: _____

City: _____State: _____

Phone: _____ FAX: _____

Sending To:

Name of Facility: _____

City: _____State: _____

Phone: _____ FAX: _____

Please forward Medical Records *Reports* for:

X-Ray **Ultrasound** **MRI** **CT Scan** **Nuclear Medicine** **Mammography**

Please forward Medical Records *FILMS / CD* for:

X-Ray **Ultrasound** **MRI** **CT Scan** **Nuclear Medicine** **Mammography**

PICK UP MAIL FAX OTHER:_____

Patient Signature: _____Date: _____

Authorized Person/Parent: _____

Relationship:_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition (not to exceed 90 days): _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it a potential for an unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules. If I have any questions about the disclosure of my health information, I can contact the authorized individual or organization making disclosure. I understand that the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS, HIV, and sexually transmitted disease.