



PATIENT INFORMATION RELEASE AUTHORIZATION

Please fill out the following form to authorize the release of information either to or from Stonebriar Medical Imaging.

PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

SOCIAL SECURITY NUMBER: _____

HOME PHONE: _____ WORK PHONE: _____

I AUTHORIZE RELEASE OF MY MEDIAL INFORMATION FROM:

I AUTHORIZE RELEASE OF MY MEDICAL INFORMATION TO:

AUTHORIZATION TO RELEASE ANY AND ALL MEDICAL RECORDS OR FILMS FOR MEDICAL TREATMENT.

A PHOTOCOPY IS VALID AS THE ORIGINAL.

THIS AUTHORIZATION MAY BE USED TO DISCLOSE ADDITIONAL MEDICAL INFORMATION AT THE PATIENT'S REQUEST BY STONEBRIAR MEDICAL IMAGING

PURPOSE OF DISCLOSURE: _____

SIGNATURE: _____ DATE: _____