



Visconti Imaging & Vein Institute

Advanced Radiology Specialists

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize the release of my films and reports from:

Facility Name: _____

Address: _____

Phone: _____ Fax: _____

To: VISCONTI IMAGING & VEIN INSTITUTE

Records Requested: _____

___ X-ray Films ___ Mammogram Films ___ Ultrasound Films

___ CT Scan Films ___ MRI Films ___ Other _____

I hereby acknowledge that authorization has been provided to release my medical information **and that this release is valid for 1 year from the date, unless otherwise specified.** I understand that all "original films" are part of a permanent medical record, property of the above named facility and are on loan for 30 days.

Permanent Transfer

Patient Signature: _____ Date: _____

Witness's Signature: _____

PLEASE NOTIFY US AT 231-439-9700 IF YOU DO NOT HAVE THE ABOVE FILMS. THANK YOU

1114 Charlevoix Avenue Petoskey, Michigan 49770
231.439.9700 231.439.VEIN
Fax: 231.439.9709