IMAGE NORTH

2922 D&M Dr.
Gaylord, MI 49735

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: ____

****We prefer all films on a CD in a DICOM format. Thank you****

____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.

Patient Signature:____________________________________ **Date**:__________

Witness's Signature: _________________________________

PLEASE NOTIFY US AT **231-439-9700** IF YOU DO NOT HAVE THE ABOVE FILMS. **IF THERE IS ANY FEE PLEASE CONTACT THE OFFICE FOR AUTHORIZATION.** THANK YOU