

UNIVERSITY CENTER IMAGING

1800 W Hibiscus Blvd., Suite 100

Melbourne, FL 32901

Ph: 321-726-3800

Fax: 321-726-3842

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ DOB: _____

Social Security Number: _____ Telephone: _____

Reason for release: _____

Records to be released: _____

Release FROM:

Name: _____

Facility: _____

Address: _____

City, State, Zip: _____

Phone: _____ FAX: _____

Release TO:

Name/Facility: University Center Imaging _____

Address: 1800 W Hibiscus Blvd., Ste 100 _____

City, State, Zip: Melbourne, FL 32901 _____

Phone: 321-726-3800 FAX: 321-726-3842

I hereby authorize the release of all medical information, including diagnosis, medical, surgical, laboratory, or radiological records of any treatments, examinations, or tests rendered to me, to include any Federal and State protected information under Florida Statute 396.459 (9) Psychiatric information, Florida Statute 397.053 and Florida Statute 396.112 Drug and/or Alcohol Abuse information and Florida Statute 381.609 (2) HIV test results (AIDS and related conditions).

I understand and direct that this authorization remain in effect for twelve (12) months or until I revoke it in writing. I hereby release the originating office or facility and its employees from any and all liability that may arise from the release of this information as I have directed.

Patient Signature: _____ **Date:** _____

If not patient:

Signature of Empowered Representative: _____

Relationship to patient: _____ Date: _____

Witness: _____ Date: _____