

REQUESTING RELEASE OF THE FOLLOWING IMAGES AND REPORTS

(We participate in Nuance PowerShare for transmitting of images)

Patient's Name	e:	D.O.	.B.:
Patient's Phone	e:	If your name has changed, what was it previously?	
	Note to our valuable patien friend. Having a prior mami appointment could avoid further than the second sec	u cannot DECOMPRESS CD images am was performed on film.	r upcoming
	U Other	and IMAGES AND RE	PORIS
Please send	requested records to: LAKE MEDICAL IMAGING 201 East Divio Ave. Suite 10	OR Name	
	801 East Dixie Ave, Suite 104 Leesburg, FL 34748	Address	
	Phone (352) 787-5858	Contact Phone	
	FAX: (352) 728-6074		
	*FAX Surgio	cal Pathology Reports to (352) 315-6328	
I authorize:	Name of Facility:		
	Address:		
	Phone:	Fax:	
	to release certain protected he	alth information (PHI) about me as requested above	> .
		disclosed for comparison and/or diagnostic evaluation tive for one year from the date signed.	on.
		n Floyd, Privacy/Compliance Officer Lake Medical Imaging , Suite 104 • Leesburg, FL 34748 • (352) 787-5858	
Patient Signature		Date	
or Personal Represe	entative/Guardian Signature	Print Name	Relationship to Patient
Witness Signature		Print Witness Name	Date

Date:_