Lake Medical Imaging

Accredited by the American College of Radiology

REQUEST FOR RELEASE OF PATIENT MEDICAL RECORDS

(We participate in Nuance PowerShare for transmitting of images)

Date:_____

Patient's Name: _____ D.O.B.: _____

Patient's Phone: _____

☐ Mammogram and any breast-related images and **COPIES OF REPORTS**
Note to our valuable patient: If this is your first mammogram with us, prior mammograms are your best friend. Having a prior mammogram available for comparison at the time of your upcoming appointment could avoid further unnecessary breast imaging or breast biopsy.
Please create DECOMPRESSED CD images
Only send file images if you cannot DECOMPRESS CD images or if the original mammogram was performed on film.

☐ Other _____ **and COPIES OF REPORT**

☐ *Surgical Pathology **REPORTS ONLY**

Please send requested records to:

☐ **LAKE MEDICAL IMAGING**
801 East Dixie Ave, Suite 104
Leesburg, FL 34748
Phone **(352) 787-5858**
FAX: (352) 728-6074

OR

☐ Name_____
Address _____
City/State/Zip _____
Contact Phone _____

***FAX Surgical Pathology Reports to (352) 315-6328**

I authorize: Name of Facility: _____

Address: _____

Phone: _____ Fax: _____

to release certain protected health information (PHI) about me as requested above.

The information will be used or disclosed for comparison and/or diagnostic evaluation.
This authorization remains effective for one year from the date signed.

Josh Floyd, Privacy/Compliance Officer
Lake Medical Imaging
801 E. Dixie Ave., Suite 104 • Leesburg, FL 34748 • (352) 787-5858

Patient Signature _____ Date _____

or Personal Representative/Guardian Signature _____ Print Name _____ Relationship to Patient _____

Witness Signature _____ Print Witness Name _____ Date _____