



Lake Medical Imaging

Accredited by the American College of Radiology

REQUESTING RELEASE OF THE FOLLOWING IMAGES AND REPORTS (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 **IMAGES AND REPORTS**

Please send requested records to:

LAKE MEDICAL IMAGING **OR**

801 East Dixie Ave, Suite 104

Leesburg, FL 34748

Phone **(352) 787-5858**

FAX: (352) 728-6074

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