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MEDICAL RECORDS RELEASE

To further insure compliance with the "Health Insurance Portability and Accountability Act of 1996", Atlantic Radiologic Imaging requests your written authorization to release health care information to outside health care facilities and send results to specific health care providers, at the discretion of the patient.

Completion of the following information is essential to update our provider database and process your request.

I, _____ (*Patient's Name*) authorize Atlantic Radiologic Imaging to release copies of my clinical records including films and/or original MRI's in connection with my care and treatment on _____ (*Date*) to the following:

<i>Doctor's Full Name</i>	<i>Complete Mailing Address</i>	<i>Phone Number</i>
1 _____	_____ _____	(____)_____-____
2 _____	_____ _____	(____)_____-____
3 _____	_____ _____	(____)_____-____

Patient's Signature: _____ Date: ____/____/____

Legal Guardian: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

STAFF USE:

UPIN# _____ MEDICAID# _____ FAX# (____) _____

(IF NOT PAR WITH MEDICAID) LICENSE # _____

Database Entry: _____ Date: ____/____/____
 (Atlantic Radiologic Imaging)