

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I AUTHORIZE _____

Address

City, State, Zip

Phone number

Fax number

Films Called For: Yes No

Date: _____ Initials: _____

Contact Person: _____

TO RELEASE MY FILMS/MEDICAL REPORTS IN YOUR POSSESSION TO:

**SAND LAKE IMAGING
9350 TURKEY LAKE ROAD
ORLANDO, FL 32819**

THIS IS A PERMANENT TRANSFER

YOUR NAME ON PREVIOUS RECORDS _____
(PRINT CLEARLY)

PATIENTS SIGNATURE

DATE

SOCIAL SECURITY NUMBER: _____

DATE OF BIRTH: _____

(Circle Items) FILMS REPORTS

EXAM:

DIAGNOSTIC X-RAY

MAMMOGRAM

ULTRASOUND

MRI

CT

DATE OF SERVICE: _____

IF FURTHER INFORMATION IS NEEDED, PLEASE CALL 407-363-2772

SG3380 09/07

PLEASE WRITE THE NAME OF YOUR LAST MAMMOGRAM FACILITY IF IT WAS NOT AT SAND LAKE IMAGING. IF YOU'VE NEVER HAD A MAMMOGRAM PLEASE LEAVE BLANK.