

**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.**