MAB
MEDICAL ASSOCIATES OF BREVARD

Diagnostic Imaging CD/Image Release Request

Form Instructions:

- Fax completed form to (321) 435-0100
- Email completed form to: mablab@mabmd.com

I hereby authorize Medical Associates of Brevard to release my health information as noted below:

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____

Patient Email Address: _____ Patient Phone #_____

Release Information to:

-This box must be completed in order for request to be processed-

Physician/Facility: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

Email address _____

Information to be released:

Unless otherwise specified, only the following information will be released:

☐ X-Ray ☐ CT Scan ☐ Ultrasound

Authorization to Release Protected Information:

Will be Delivered to Physician Listed Above

Date of Study:_____

Request Needed By (date):_____

Type of Study:

☐ **Head**

☐ **Chest**

☐ **Abdomen**

☐**Other:**

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. The authorization will expire ninety (90) days from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ **Signature**: _____ Patient or Legally Authorized Representative

_____ Printed Name of Patient or Legally Authorized Representative