# Request for Release of Patient Medical Records

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_____ Mammogram AND **COPIES OF REPORTS**
_____ Other ______________________________________________ **AND COPIES OF REPORTS**
______________________________________________ **AND COPIES OF REPORTS**
_____ *Surgical Pathology REPORTS ONLY

_____ **LAKE MEDICAL IMAGING**
**801 East Dixie Ave, Suite 104**
**Leesburg, FL 34748**
**352-787-5858**

**OR**

_____ Name __________________________________
(Address) _______________________________
(City/State/Zip) __________________________
(Contact Phone)__________________________

*****Create CD images DECOMPRESSED, if you cannot DECOMPRESS, please send film.*****

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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 the following purpose:
  Comparison and/or diagnostic evaluation or for correlation with biopsy/aspiration.
- This authorization remains effective for one year from the date signed.
- I do not have to sign this authorization as a condition for receiving treatment from Lake Medical Imaging
- When information about me is used or disclosed pursuant to this authorization, I understand it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule.

Any questions may be submitted to the Privacy/Compliance Officer at:
Josh Floyd, Privacy/Compliance Officer
Lake Medical Imaging
801 E. Dixie Ave., Suite 104
Leesburg, FL 34748

| _____________________________ | _____________________________ | _______________ | _______________ |
|---|---|---|---|
| Patient Signature | Print Patient Name | Patient DOB | Daytime Phone # |

______________________________ ______________________________ ____________________
or Personal Representative/Guardian Signature Print Personal Representative/Guardian Name Relationship to Patient

_____________________________ _____________________________
Witness Signature Print Witness Name

_____________________________
Date Signed

Rev 1/2016