Lake Medical Imaging
Accredited by the American College of Radiology

Request for Release of Patient Medical Records

Date: _____

Patient Name _____ Patient D.O.B. _____

Patient Phone _____

____ Mammogram and any breast-related studies and **COPIES OF REPORTS**

Please create DECOMPRESSED CD images
Only send film images if you cannot DECOMPRESS CD images or if the original mammogram was performed on film.

____ Other _____ **and COPIES OF REPORTS**

____ *****Surgical Pathology **REPORTS ONLY**

Please send requested records to:

____LAKE MEDICAL IMAGING **OR** **_____** Name _____
801 East Dixie Ave, Suite 104 Address _____
Leesburg, FL 34748 City/State/Zip: _____
Phone **352-787-5858** Contact Phone:_____

***Fax Surgical Pathology Reports to 352-315-6328**

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 comparison and/or diagnostic evaluation.
This authorization remains effective for one year from the date signed.

Josh Floyd, Privacy/Compliance Officer
Lake Medical Imaging
801 E. Dixie Ave., Suite 104
Leesburg, FL 34748
352-787-5858

_____

Patient Signature Date

_____

or Personal Representative/Guardian Signature Print Name Relationship to Patient

_____

Witness Signature Print Witness Name

Date Signed: _____ Revised 10/2017