



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 **IMAGES 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 _____ **IMAGES AND COPIES OF REPORTS**

_____ ***Surgical Pathology REPORTS ONLY**

Please send requested records to:

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

OR

_____ Name _____
Address _____
City/State/Zip: _____
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