South Florida Diagnostic Imaging

11801 SW 90 Street, Suite 102, Miami, Fl 33186 • Tel 305-270-6001 Fax 305-270-6955

MEDICAL RECORD RELEASE FORM

By signing this form, I authorize ____
(Name of Facility or Doctors Office)

to release copies of (type of exam): ____

- ☐ Images (CD)
- ☐ Corresponding radiology reports
- ☐ Surgical and pathology reports for: *(complete section below)*

1. *Surgery/procedure:* __________________________ *Date of Surgery/procedure:* __________
2. *Surgery/Procedure:* __________________________ *Date of surgery/procedure:* __________

needed for evaluation and comparison of exams related to the following diagnosis:

____.

Please fax or mail the requested documents and/or CD to:

South Florida Diagnostic Imaging
11801 SW 90 Street, Suite 102
Miami, Fl 33186
Tel 305-270-6001
Fax 305-270-6955

_______________________________________ _______________________________

Patient Name (Print) Signature

_______________________________________ _______________________________

Patient's Date of Birth Date

____

Authorized Personal Representative
(if applicable)

☐ Minor ☐ Power of Attorney