South Florida Diagnostic Imaging

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ **DOB:** _____

Patient Signature: _____ **Date:** _____

The above patient authorizes the following healthcare facility to disclose the requested medical records to SFDI, for Continuity of Care:

Facility Name: _____ **Phone:** _____

Facility Address: _____ **Fax:** _____

City, State, Zip: _____

Dates and Type of Information to Disclose:

- ○ **Up to (3) years of prior mammography and breast ultrasound images on CD with reports.**
- ○ **CD for prior** _____
- ○ **Report for prior** _____
- ○ **Specific Information Requested:** _____

_____

Please Release to (SFDI):

South Florida Diagnostic Imaging

11801 SW 90 Street, Suite 103

Miami FL 33186

Tel: 305/270-6001 Fax: 305/270-6955

Medical Records

Delivery or Pick Up

___ **Will be delivered to SFDI**

___ **To be picked up by SFDI courier**

___ **Patient will take with them**