SUMMIT IMAGING-HIPAA RELEASE FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

RELEASE OF MEDICAL INFORMATION

(This form applies to your personal medical records only)

_____ I hereby authorize, upon my request, the release of any and all of my medical records.

Please print authorized people's name and relationship below:

1) _____ Relationship:_____

2) _____ Relationship: _____

Your reports will automatically be sent to your ordering doctor

** This release of information will remain in effect until terminated by me in writing**

If you choose your information NOT to be released to any one please Initial here: _____ My information is not to be released to anyone.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____