1114 Charlevoix Ave.
Petoskey, MI 49770
Phone: 231-439-9700
Fax: 231-439-9709

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ **Date of Birth**:_____

I hereby authorize the release of my films and reports from:

Facility Name:_____

Address:_____

Phone:_____ **Fax:** _____

To: The Staff at Visconti Imaging • Vein

Records Requested: **Please send over ALL breast related FILMS (i.e. mammograms, breast ultrasounds, or breast MRI, ect…) and REPORTS.**

****We prefer all films on a CD in a DICOM format. Thank you****

I hereby acknowledge that authorization has been provided to release my medical information **and that this release is valid for 1 year from the date, unless otherwise specified.** I understand that all "original films" are part of a permanent medical record, property of the above named facility and are on loan for 30 days.

Patient Signature:_____ **Date**:_____

Witness's Signature: _____

PLEASE NOTIFY US AT **231-439-9700** IF YOU DO NOT HAVE THE ABOVE FILMS. **IF THERE IS ANY FEE PLEASE CONTACT THE OFFICE FOR AUTHORIZATION.** THANK YOU