ADVANTAGE+ MRI
Excellence in High Field Imaging

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION (PHI)

This form allows us to release information, including today's MRI report, to your referring doctor and any other health care provider such as your primary care physician and specialist.

Please list names and phone/ fax numbers below:

_____

_____

_____

_____

PATIENT NAME:_____

Date of Birth: _____ /_____/_____

Type of Exam: (body part)_____

Signature:_____ Date: _____

If signed other than the patient, please indicate your relationship to the patient: _____