Release of Medical Records

I, _____, authorize Advanced Diagnostic Imaging (DBA-Advanced Health) or the custodian of record to release confidential health information about me, by releasing a copy of my medical records, to the individual or organization listed below.

Patient Name: _____ **Date of Birth:** ___/___/_____ **Last 4 of SSN #:** _____

Street Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

Phone: (___) ____-_____ **Email:** _____

Release Information From:

Provider/Facility: _____ **Phone:** (___) ____-_____

Street Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

Fax: (___) ____-_____ **Email:** _____

Please select a date option:

- ☐ All Dates of Service
- ☐ Limited Date of Service: ___/___/_____ to ___/___/_____

Please indicate what is to be included in this request:

- ☐ All Medical Records
- ☐ Medical Record request limited (select from the following):
  - ☐ Demographics
  - ☐ Office Progress Notes
  - ☐ Consultation Notes
  - ☐ Operative Reports
  - ☐ Hospitalizations
  - ☐ Labs/Pathology
  - ☐ Radiology Reports
  - ☐ Other (Please Specify): _____

This information may be disclosed to and used by the following individual or organization:

Name: _____ **Phone:** (___) ____-_____

Street Address: _____ **City:** _____ **State:** ____ **Zip Code:** _____

Fax: (___) ____-_____ **Email:** _____

Patient/Gaurdian Name: _____ **Relationship to Patient:** _____

Patient/Gaurdian Signature: _____ **Date:** _____