CenterLine Imaging Consultants
23772 West Rd, Suite #235
Brownstown Township, MI 48183
Phone: 586-899-1499 Fax: 586-992-4042

Authorization to Release Medical Information

Location of Images: _____

_____

Patient Name: _____

DOB: _____ **ID/Health Record #:** _____

I hereby authorize the release of the following information:

☐ Imaging – *please send either CD/Digital Media or hardcopy films.*

Date(s) of study: _____

Region(s): _____

☐ X-Ray ☐ MRI ☐ CT ☐ Bone Scan ☐ Densitometry ☐ US

☐ Radiology Reports

☐ Other Medical Records: _____

☐ Medicolegal Reports

Information is to be released to:

CenterLine Imaging Consultants
23772 West Rd, Suite #235
Brownstown Township, MI 48183

For the purpose of: Review

Duration: This authorization shall remain in effect for one year unless otherwise specified.

Revocation: This authorization is subject to written revocation by the patient at any time, effective upon receipt.

Signed: _____

☐ Patient ☐ Spouse ☐ Parent ☐ Guardian

Date: _____