# Imaging/Radiology Medical Authorization Release Form

## Patient Information

Full Name

Date of Birth

Phone Number

Address

Insurance Provider

Policy Number

## Provider and Facility Information

Referring Physician

Imaging/Radiology Facility

Facility Address

## Authorization and Release

I authorize the release of my medical imaging/radiology records as necessary for insurance claims processing.

☐ X-ray ☐ CT Scan ☐ MRI ☐ Ultrasound

Other (Please specify)

Purpose of Release

This authorization is valid for the specific dates or services indicated and may be revoked at any time with written notice.

Patient Signature
Date