



MRI MEDICAL RECORDS RELEASE

Instructions to obtain MRI/CT Imaging and Reports: Please fill out and sign the release form below. Then send and/or bring this form to the imaging facility where you had your most recent imaging completed.(preferably withing the last 2 years) The facility then will be able to send your MRI/ CT imaging and reports to us via mail at the address listed below. If you have any trouble please contact MRI Review team at 321-775-1299.

I hereby authorize (**Facility Information: where you had your most recent imaging completed within the last 2 years.**)

Provider, Facility

Address, City, State, Zip Code

Phone

Fax

To release ALL medical records regarding MRI / CT / Imaging and reports on my behalf:

From: _____

To: _____

Patient Information:

Patient Name: _____

Date of Birth: _____

Phone: _____

Please mail records to:

**Deuk Spine Institute
Attn: MRI Review
7955 Spyglass Hill Rd. Ste A
Melbourne, FL 32940**

I understand these records may contain information from other health care providers, as well as information which is administrative in nature. This information will be given only to those specified on this form and only through the expiration date stated below. I also understand I have the right to revoke this authorization at any time through written notice and that written notice must include 1) the patient's name, social security number and date of birth, 2) make reference to this specific authorization and the name so those authorized by this form to receive information, 3) a statement that the patient wants to revoke this authorization, the effective date of revocation, and the signature of the patient or a legal guardian. I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by federal privacy laws or regulations.

This authorization will expire 1 year from the date specified below.

Patient/Legal Representative Signature

Date

Witness Signature

Date