Medical Imaging & Therapeutics Authorization to Release Diagnostic Imaging Records

I hereby authorize the release of my records from the facility/physician listed below to MIT.

Facility / Physician Name: _____

Address:_____ City/State:_____

_____

Patient Name:_____ DOB:_____

Information to be disclosed to:
For the Purpose of: *Comparison*

Medical Imaging & Therapeutics
13837 NE 86th Ter, Lady Lake FL 32159
PH: 352/261-5502
FAX: 352/350-5942

Information to be disclosed shall include:

❑ Reports ❑ CD's ONLY of Diagnostic Imaging Studies

Affirmation of Release:
I give the above named facility permission to release the records indicated on this form to MIT. I understand this authorization will expire two years from the date it was signed. I may refuse to sign or revoke this authorization at any time. The revocation will take effect on the date it is received in writing. I understand if I do refuse to sign this authorization MIT cannot retrieve previous studies for comparison purposes and I release MIT of liability.

Signature Patient / Legal Representative: _____

Dated: _____

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SUBMIT FORM