Authorization to Release Medical Records

ⓘ If any section of this form is incomplete, this form may be invalid.

Patient Information

Full Name(1)*

Date of Birth*

Email*

Phone*

(1) If the person submitting the request for medical records is someone other than the patient or a parent of a minor patient(e.g., court appointed guardian; durable power of attorney), you may be required to include supporting documentation ofyour authority to act on behalf of the patient with your request.

Requested Imaging Information

Media ☐ Paper ☐ CD ☐ USB

How to receive ☒ Mail

Authorization for ☒ Radiology report ☒ Radiology Images Exam type (e.g. CT, MRI) _____ Exam date _____

Recipient Information (SecondOpinions)

Recipient* Second Opinions a Division of USARAD Holdings Inc.

Current Address* 3101 North Federal Highway Suite 400

Email* support@secondopinions.com

City Fort Lauderdale

State Florida

Zip 33306

Phone 855-573-2663

Authorization Information

I, the undersigned, authorize (Imaging Facilities Name) _____ to release medical information as indicated above.
This authorization may be revoked in writing.
I understand revocation will not apply to information that has already been released in response to this authorization.
I understand that once the information is released pursuant to this authorization, it may be re-disclosed by the Recipient and the information may not be protected by privacy regulations.

Signature of patient or patient's representative*

Date*

If signed by other than patient

Print Name (Legal Representative)*

Legal relationship to patient*