



Saving Lives Through
Early Detection

Authorization to Records Department for the Release of Medical Records

First Name: _____ MI: _____ Last Name: _____

Phone: _____ Date of Birth: _____

Address(city, state, zip): _____

Release medical records from:

Medical Facility: Life Guard Imaging II, LLC
Address: 3815 E. Bell Road, Suite 1400, Phoenix, AZ 85032

Phone: (602) 755-5001
Fax: 602-755-5002

How would you like your medical records delivered?

Mail records to requested address

Name (Medical Facility): _____

Address: _____ Apt/Unit/Suite: _____

City: _____ State: _____ Zip Code: _____

Fax record to medical facility listed below

Name (Medical Facility): _____

Fax: _____ ATTN: _____

I, or an authorized person, will pick up
(proper ID and letter required)

Purpose of Release: Continued Medical Care Personal Information Other:

Requested PHI: Diagnostic Reports CD Images USB Images

Date of Exam: _____ Type of Exam: _____

I, _____ (Legal Name), hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/person/facility/entity. Each time new records are requested; a new request is required. This authorization is not valid if not filled out completely. A copy of this consent is as valid as the original.

I understand that I am free to revoke this release authorization at any time by notification in writing to Life Guard Imaging II, LLC, ATTN: Medical Records, 3815 E. Bell Road, Suite 1400, Phoenix, AZ 85032. I understand the revocation will not apply to information that has already been release in response to this authorization.

There is a \$25.00 charge for any and all CDs or USBs requested by patients.

Signature: _____ Date: _____

Picking Up Protected Health Information Requires Identification

MRN: _____ ID verified & scanned: YES NO Employee Signature: _____

of CD's: _____ # of USB's: _____ Amount Due: \$ _____

*Anyone picking up PHI, must have a valid ID. The person authorized to retrieve PHI on behalf of the patient must have a signed letter from the patient before records can be released.