Life Guard Imaging | Saving Lives Through Early Detection

Please email to **customercare@lifeguardimaging.com** or mail to **3001 N Rocky Point Dr E, Suite 185 Tampa, FL 33607**

Authorization to Records Department for the Release of Medical Records

Legal First Name: _____ **Legal Last Name:** _____

Phone: _____ **Date of Birth:** _____

Address(city, state, zip): _____

Release records from

Medical Facility: Life Guard Imaging **Phone:** (813) 524-1010

Address: 3001 N. Rocky Point Dr. E., Suite 185, Tampa, FL 33607 **Fax:** 813-582-5525

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, ATTN: Medical Records, 3001 N. Rocky Point Dr. E., Suite 185, Tampa, FL 33607. 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.