

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.