## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____

SSN: _____

Date of Birth: _____

Phone # we can contact you at: _____

**I request and authorize:**

PET Imaging Institute of South Florida
1150 North 35th Avenue, Suite 665
Hollywood, FL 33021
Phone: 954-981-6668
Fax 954-981-5944

PET Imaging Institute of South Florida
603 N. Flamingo Road, Suite 155
Pembroke Pines, FL 33028
Phone: 954-981-6668
Fax 954-981-5944

**To release healthcare information on the above patient for the purpose of:**

- Continued health care or treatment
- Other: _____

**To the following party:**

Name _____ Phone ( ) _____-_____
Address _____ Fax ( ) _____-_____
City/State _____ Zip Code _____

**Information to be released:**

Current Medical records

**This authorization will expire**

on [date] _____ /_____ / _____ or upon [event] _____ and no later than 90 days after the date it was signed. This authorization may be revoked at any time by the patient in writing, providing the information has not already been disclosed. Planned Parenthood of Western Washington will not condition treatment or the provision of care on the completion of this authorization. This information should not be re-disclosed by the recipient without the patient's additional authorization or consent unless required by law.

Signature _____ Date Signed ____ /____ /____