PET Imaging Institute of South Florida

Authorization For Release of Medical Records

Patient #: _____

Patient Name: _____

Date of Birth: _____

Social Security #: _____

Patient Address: _____

_____

From: PET Imaging Institute of South Florida (954)981-6668

To: _____

Address: _____

I authorize you to furnish PET Imaging Institute of South Florida and all medical records and other documentation in your possession regarding my care and treatment.

I understand these records may contain information from other health care providers, as well as information, which is administrative in nature. I specifically consent to the release of any information contained in the medical record which may relate to infection with human immunodeficiency virus (HIV), AIDS, or related records.

I authorize you to transmit this information by facsimile transmission (**medical records**). I authorize you to release the information personally (**films**) to an authorized representative of PET Imaging Institute of South Florida is deemed necessary.

I release you from any liability for breech of confidentiality, misdirection or transmission, or failure to receive transmission if my records are transmitted by fax.

This release is valid until revoked by written notice to PET Imaging Institute of South Florida. I hereby waive any privilege I may have to said information. I have read and fully understand this Authorization for the Release of Medical Records. All blank statements requiring completion were filled in before I signed this Authorization for the Release of Medical Records.

_____ _____

Patient/Legal Representative Date

_____

Witness