

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT IDENTIFICATION Name: _____
Date of Birth _____ S.S.# _____
Maiden/Other names known by: _____

PROVIDER
(Who is releasing information) **Williamson Imaging Services, LLC.**

RELEASE RECORDS TO: Name: _____
(Person or Place records should be sent) Address: _____
City/State/Zip _____

DATES OF TREATMENT Dates: _____

INFORMATION REQUESTED FROM:

Vanderbilt Imaging Services, LLC. Williamson Imaging Services, LLC.
dba – Hillsboro Imaging dba. – Cool Springs Imaging

Vanderbilt-St Thomas Imaging

PURPOSE OF RELEASE Medical Care Insurance At the request of the patient
 Other, Please Explain: _____

I understand that my medical record may also include information on diagnosis/treatment related to **psychiatric or psychological conditions, drug and/or alcohol abuse, acquired immune deficiency syndrome (AIDS), and/or HIV status, and/or any Radiological findings.**

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

PLEASE INITIAL

THE STATEMENT THAT APPLIES I do _____ do not _____ authorize this information to be released.
(You must initial one) **Limitations, if any:** _____

TIME LIMIT

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____

Signature of Patient/Legal Representative: _____ Date: _____

Relationship to Patient: _____