



MEDICAL RECORD RELEASE OF HEALTH INFORMATION AUTHORIZATION FORM

I hereby authorize Radiology Ltd. to obtain any or all of my outside medical records for the purpose of comparison and /or assisting in the interpretation of my procedure(s). A photocopy or electronic transmittal of this signed release form shall be considered as effective and valid as the original. I understand that the films and filed report(s) are the property of Radiology Ltd. and will only be released to authorized requesters.

Patient Name: _____ Date of Birth: _____

Alias Name: _____

Patient Signature: _____ Date: _____
(Valid for only one year)

Exams Needed: _____

**If you have any questions or need additional information,
please contact us at: (520) 545-1822 or fax us at: (520) 326-7989.**

The information contained in the facsimile may be Confidential and/or Legally Privileged information intended only for the use of the entity or individual named above. If you have received this communication in error, immediately notify us by telephone and we will arrange for the return of this facsimile. Thank you.