Derry Imaging Center
Overlook Medical Park
6 Tsienneto Road, LL100
Derry, NH 03038

Phone: 603-537-1363 Fax: 603-537-1324

Authorization Form for Use and Disclosure of Protected Health Information

Patient's Name: _____

DOB: _____ Phone: _____

I hereby authorize **DERRY IMAGING CENTER** to **RELEASE / OBTAIN** my Protected health Information, including copies of my reports **TO / FROM** the facility below:

FACILITY: _____

ADDRESS: _____

_____

Please specify (**circle**) which films: ****PLEASE INCLUDE REPORTS****

X-RAY **ULTRASOUND** **MAMMOGRAM** **MRI** **CT**

Patient's Signature: _____

Date: _____