DERRY IMAGING | Derry Windham Bedford

Authorization Form for Use and Disclosure of Protected Health Information

Patient's Name: _____

DOB: _____ Phone: _____

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

FACILITY: _____

ADDRESS: _____

_____

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

□ X-RAY □ ULTRASOUND □ MAMMOGRAM □ MRI □ CT □ PET/CT

Patient's Signature: _____

Legal Guardian Signature (if patient is a minor): _____

Date: _____

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