



PERMISSION TO DISCUSS MEDIAL INFORMATION

All medical records are confidential. We require written authorization to release medical information to anyone other than the patient. By signing the authorization below, you are giving Derry Imaging Center permission to discuss the information contained in your medical chart with another individual.

I, _____, give the physicans and staff of Derry Imaging Center permission to discuss my medical information (including but not limited to appointments and procedures) with:

Please list names below:

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____