



Regents Imaging

3909 Waring Road, Suite C, Oceanside, California 92056
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize the release of requested information from my medical record, obtained in the course of my diagnosis and treatment including, if appropriate, psychiatric and/or alcohol and/or drug abuse records to:

The disclosure of records authorized herein is requested for the following purpose:

Such disclosure shall be limited to the following specific types of information:

- _____ MRI Reports
- _____ Operative Reports
- _____ Billing Records

This authorization conforms with the above regulations.

Records obtained as authorized by this consent will be maintained in accordance with federal regulations which prohibit re-disclosure.

This authorization is valid for six months unless revoked in writing earlier.

Signature _____ Date: _____
(Patient)

Signature _____ Date: _____
(Legal guardian/representative)

Witness _____ Date: _____

Print Patients Full Name Date of Birth