SPRING HILL

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Authorization for Records Release

Patient Name: _____ Acct #: _____

Date of Birth: _____ Social Security #: _____

I hereby authorize Spring Hill MRI access to my medical records with respect to my medical condition or treatment. These records are being requested to assist in the continuity of my patient care at Spring Hill MRI. I understand that I may revoke the authorization at any time, and in order to do so, I must send written notice to the healthcare provider(s).

Signature: _____ Date: _____

I hereby authorize Spring Hill MRI to release or disclose my medical records to the following people:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I understand that I may revoke the authorization at any time, and in order to do so, I must send written notice to the healthcare provider(s).

Signature: _____ Date: _____