



Authorization For Radiology Image Release

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WE REQUIRE 48 HOURS NOTICE TO PROCESS A CD REQUEST.

PLEASE PRINT CLEARLY

Full Name: _____

MRN#: _____ (For Clinic Use Only)

Date of Birth: _____

Phone (Home): _____ (Work): _____

I, the undersigned, authorize and request **Melbourne Internal Medicine Associates (MIMA)** to copy or request the following information from my image CD.

Exam Type: _____

Release to Person/Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Please Check One: **Hand Carry** **Courier**

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ID **DOB** **SS#**

PERSON PICKING UP FILMS:

PATIENT **SPOUSE** **OTHER:** _____

Print Name: _____ Date: _____

Signature: _____