Maximum Resolution Imaging
THE NEW ERA OF IMAGING
www.maxresolutionimaging.com

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Phone: (832) 400-2731

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT IDENTIFYING INFORMATION:

Patient Name: _____
Date of Birth: _____
Address: _____ City: _____ State: _____
Zip Code: _____
Phone #: _____-_____-_____ Cell Phone #: _____-_____-_____
Today's Date: _____

I hereby authorize Maxiumum Resolution Imaging to release my medical records to:

Full Name: _____
Mailing Address: _____
Phone #: _____-_____-_____ Fax Number: _____-_____-_____

Specific Information to be disclosed:

☐ Report(s) Procedure(s)/Dates _____

☐ CD(s) or Film(s) Procedure(s)/Dates _____

This health information is needed for:
Continuing Medical Care /Personal Use / Legal Reasons/ Insurance/ Other _____

_____
Patient/Recipients Name (Print) Signature Date:

_____
Witness

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FOR OFFICE USE ONLY

PICK UP/MAIL OUT DATE: _____ ISSUED BY: _____ ID CHECKED: _____