Tel: (928) 216-5250 • Fax: (928) 216-5254
5448 South Highway 260, Suite 110 • Lakeside AZ 85929
scheduling@pmicaz.com

MEDICAL RELEASE/REQUEST FORM

PATIENT INFORMATION:

Name:____

Date of Birth:_______________________ Phone:_______________________

RECORDS TO BE RELEASED:

____**IMAGES / REPORTS**

INFORMATION REQUESTED FROM: ☐ PREMIER MOUNTAIN IMAGING CENTER

Name:____

Address:____

Phone:_______________________ Fax:_______________________

RELEASE INFORMATION TO: ☐ PATIENT ☐ PREMIER MOUNTAIN IMAGING CENTER

Name:____

Address:____

Phone:_______________________ Fax:_______________________

Email (if applicable):____

Deliver Via: ☐ **E-Mail** ☐ **Fax** ☐ **Mail** ☐ **Pick-up Date:________________ Time:__________**

PERMISSION: ☐ CONTINUATION OF CARE

I, *(Patient Name)*_______________________________, hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record or a summary, or narrative of my protected health information to the physician, person, facility, or entity.

Signature:_______________________________ Date:_______________________

Office Use Only: ☐ CD Verified (Initials) ___________

Method of Delivery: ☐ In-Hand ☐ Faxed ☐ E-Mailed ☐ Mailed (Date/Initials) _____________