PREMIER
MOUNTAIN IMAGING CENTER

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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:_____

Send Via: ☐ E-Mail ☐ Fax ☐ Pick-Up ☐ Mail

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:

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