DOCTORS IMAGING | ADVANCED RADIOLOGY. TRUSTED CARE.

4204 TEUTON STREET - METAIRIE, LA 70006

RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____

If you have had previous tests done at another facility, please mark what those exams were and at what facility they were performed. If necessary, we will obtain those records as the information contained in them may be helpful in the care we provide you today.

Information Requested:

☐ **X-Ray & Report**	☐ **Operative Report**	☐ **Lab Report**
☐ **X-Ray Films/CD**	☐ **Pathology Report**	☐ **History/Physical**
☐ **Consultation Report**		

Facility_____ Procedure_____ Date performed_____

Release records to: Doctors Imaging Services
Medical Records Department
4204 Teuton Street
Metairie, La. 70006
Phone 504-883-8111
Fax 504-883-3555

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/or alcohol abuse, immune deficiency syndrome (AIDS), and/or HIV status.

I understand that this authorization may be revoke in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition.

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

_____

Signature of Patient/Legal Representative

_____

Relationship to Patient and/or Date