AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

TODAY'S DATE: _____

To: St. Thomas Radiology Associates, LLC
Paragon Medical Building, Suite 103
9149 Estate Thomas
St. Thomas, VI 00802

Fax #: 776-0228

Requesting Physician: _____

I, _____, herby authorize the release
Print Patient Name
Of: PLEASE CHECK BELOW

___ All Medical records (REPORTS)

___ OR if specific dates and studies, please specify _____
_____

___ All PACS Images

___ OR if specific dates and studies, please specify_____
_____

___Temporary PACS Images access (no more then 30 days)

Date of Service: _____

Study: _____

Patient's Signature: _____Date of Birth _____

Mailing Address: _____

_____