PROHEALTH
Advanced Imaging

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____ (DOB): _____

Hereby authorize _____

Phone Number: _____ Fax Number: _____

To release my medical records to ProHealth Advanced Imaging.

THE FOLLOWING EXAM IS NEEDED

CT / MRI / US ON _____

_____ REPORTS / _____ FILMS / _____ BOTH FILMS & REPORTS

Patient Signature : _____ Date: _____/_____/_____

Could you please comply with this request as soon as possible or if there's something else needed please call us at (818) 710-6011.

Thank you.

ProHealth Advanced Imaging.