RELEASE OF INFORMATION

3T Imaging is hereby authorized to obtain and/or release copies of all pertinent hospital, clinical, test, surgical, physician and medical reports; radiological films and/or transcripts for:

Patient Information	For Office Use Only
Patient Name:	
Phone Number:	
Social Security Number:	
Date of Birth:	

Furthermore, a photocopy and/or facsimile of this release may be accepted and have the same authority as this original.

I understand that this information is necessary for a complete diagnostic review by 3T Imaging and that refusal to provide this authorization could adversely impact the diagnostic review. I further understand that the results from the examination(s) performed at 3T Imaging will be sent to the referring physician and any other physicians, whom I direct to receive the review.

Information disclosed under this authorization may not be protected under the federal privacy regulations, if physicians, to whom reports are sent, re-disclosed that information.

I understand that I may revoke this authorization by submitting written revocation to 3T Imaging at any time. Otherwise, this authorization shall remain valid until revoked and will expire 1 year after signing. I also understand I am entitled to a copy of this notice for my records.

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Signature of Patient or Authorized Agent Date

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Relationship to Patient