UP&OPEN IMAGING
UPRIGHT MRI

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Name of Patient: _____ Social Security Number: _____

Date of Birth: _____ Phone Number: _____

I, the undersigned, authorize the release of MRI reports or images pertaining to the above named patient. Up & Open Imaging may release the above named patient's MRI reports or images to:

Name: _____ Relationship to Patient: _____

Phone Number: _____ Fax Number: _____

Address: _____

I understand that these records are confidential and cannot be disclosed without written authorization, except when otherwise permitted by law.

Signature: _____ Date: _____
Patient or Legally Authorized Representative

Printed Name: _____ Relationship to Patient: _____