Battlefield Imaging
4700 Battlefield Pkwy
Suite 100
Ringgold, GA 30736
(706)806-0170

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME: ______________________________ DATE OF BIRTH: _________________

I authorize ____ to release to:

____ for the following purposes:

____.

I authorize release of information covering treatment from: ___________________________________

____ including

specifically the following portions of the record:

FLUORO CT NM US RD MAMMOGRAM MRI PET BONE DENSITY

This authorization expires 90 days from the below date, and it covers only treatment prior to this date. The imaging center is authorized to furnish this information even though the confidentiality of the information may be protected by federal or state laws and regulations. The imaging center is complying with this authorization.

DATE: _________________ PATIENT: ____________________________________

FILMS: ________________ REPORTS: _______________