MEDICAL IMAGING
Center of Southern California, Inc.
Santa Monica • Beverly Hills

HIPPA AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize *Medical Imaging Center of Southern California* to release my records to:

Facility Name/Physician #1: _____

Address: _____

City_____ **State**_____ **Zip** _____

Phone number: _____ **Fax number: :** _____

Type of Imaging: _____

Facility Name/Physician #2: _____

Address: _____

City_____ **State**_____ **Zip** _____

Phone number: _____ **Fax number: :** _____

Type of Imaging: _____

_____ _____

Name of patient (Print) **Signature of patient**

_____ _____

Date of birth **Date**

Health care information is personal and sensitive. This is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional consent as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. IMPORTANT WARNING: These documents are intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that nay dissemination, distribution, or copying of this information is strictly prohibited. If you have received this communication in error. Please immediately notify us by telephone and return the original message or destroy it.

2811 Wilshire Boulevard Santa Monica, CA 90403

(310) 829-9788 Fax: (310) 453-5532