



**MEDICAL RECORDS AUTHORIZATION AGREEMENT**

**FAX TO: 212-879-3846**

**OR MAIL TO ADDRESS AT BOTTOM OF PAGE:**

Medical Imaging of Manhattan; Attn: Medical Records

I \_\_\_\_\_ request to release my (check below)  
(PRINT NAME)

**that were taken** (please list dates in the lines provided):

<input type="checkbox"/> Mammogram	<input type="checkbox"/> Sonogram	<input type="checkbox"/> MRI	<input type="checkbox"/> Bone Densitometry	<input type="checkbox"/> Other
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

<b><u>CONTACT INFORMATION</u></b>	
Daytime Phone #: (____) _____	Date of Birth: ____/____/____
Evening Phone #: (____) _____	E-mail: _____

<p><b>Are you leaving Medical Imaging of Manhattan?</b> (Please check one):    <input type="checkbox"/> <b>YES</b>    <input type="checkbox"/> <b>NO</b></p> <p><b>If "YES", please check the reason(s) that applies:</b></p> <p><input type="checkbox"/> Medical insurance            <input type="checkbox"/> Financial Difficulties            <input type="checkbox"/> Moving (to a new city, state, etc)</p> <p><input type="checkbox"/> Other-Please explain: _____</p> <p><b>If "NO", please check the reason(s) that applies:</b></p> <p><input type="checkbox"/> Appointment with a breast surgeon or oncologist .....When? ____/____/____</p> <p><input type="checkbox"/> For my own records    <input type="checkbox"/> Other _____</p>
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Since 9/11/03 Medical Imaging of Manhattan stores all images in Digital format only, and no films are printed at the time of service. Our patients are responsible for the care and storage of all films prior to this date.

Your record request will take **3-5 business days** to complete, unless otherwise arranged. The process of printing your records will not begin until written authorization and any applicable payment is received.

\_\_\_\_\_  
 Patient or Legal Guardian Signature of Acknowledgement \_\_\_\_\_  
 Date

