AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Phone: 561.496.6935
Fax: 561.496.6936

Patient Information Date: _____

Name (First, Middle and Last)
Date of Birth: Email Address:
Phone Number: Social Security Number (last 4 digits) XXX-XX-
Street Address: City: State: Zip:

Name of Healthcare Provider/Physician/Facility

Name/Facility:
Phone Number: Fax Number:
Street Address: City: State: Zip:

Information requested:
- ☐ Medical Records/Reports/Prior Imaging/Clinical Notes Pathology Reports/
- ☐ Biopsy (Fax to 561-853-3444)
- ☐ Mammogram and Breast Ultrasound Images on DICOM CD / Reports
- ☐ Other

Purpose of release:
- ☐ Continuing Care ☐ Insurance ☐ Litigation ☐ Personal Use
- ☐ Other

To release records to:

☐ Boca Raton:	8142 Glades Road, Boca Raton, FL 33434
☐ Delray Beach:	15340 Jog Road Ste 160, Delray Beach, FL 33446
☐ East Boynton Beach:	3601 PGA Blvd Ste 100, Palm Beach Gardens, FL 33410
☐ Palm Beach Gardens:	1425 Gateway Blvd Ste 100, Boynton Beach, FL 33426
☐ West Boca Raton:	23071 State Road 7, Boca Raton, FL 334287
☐ Wellington:	2565 S State Road 7, Wellington, FL 33414
☐ Wellington Women's Center:	2863 S State Road 7, Wellington, FL 33414
☐ West Boynton Beach:	6080 Boynton Beach Blvd Ste 140, Boynton Beach, FL 33437
☐ West Palm Beach:	1572 Palm Beach Lakes Blvd Ste 2, West Palm Beach, FL 33401

Statement of Authorization:

I hereby authorize you to release to Diagnostic Centers of America, LLP d/b/a RAYUS Radiology, or its representatives, the release of the following medical records and fax to 561-496-6936. The purpose of this request is for comparison to previous treatment/ surgery/effectiveness or as comparison to recent procedure, if prior procedures performed.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law to disclose medical information. This authorization is for full disclosure of all records, including but is not limited to: history, clinical findings; diagnosis; treatment; assessment; recommendations for further care; names of health care personnel; and any other information that may be related to drug, alcohol, and psychiatric conditions, and/or sexually transmitted disease, including Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome information. Such records will be disclosed unless you specify below any information you wish to be excluded. I understand that this is intended for confidential medical information.

This authorization expires on the following date, event or condition: Expiration Date:

Exclusions:
If I do not specify any expiration date, event or condition, this authorization will not expire.

Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notice to Diagnostic Centers of America, LLP d/b/a RAYUS Radiology. A photocopy/fax of this authorization will be treated in the same manner as the original.

I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, its employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

☐ **Patient** ☐ **Authorized Representative**

_____ _____

Signature of Patient/Responsible Party **Date**