Ocean Medical Imaging

Milton Medical Park
611 Federal Street, Milton DE 19968
Tel: (302) 684-5151 Fax: (302) 684-1977

Authorization for Release of Patient Identifiable Health Information

Date: ____/____/____ **Social Security Number:** _____

Patient's Name: _____ **D.O.B.:** _____/_____/_____

I hereby authorize _____ **to release to Ocean Medical Imaging:**

Film(s)/Disc/Reports

Date(s): _____ Procedure(s): _____
_____ _____
_____ _____

This health information is needed for:
Circle One

Continuing Medical Care
Legal Reasons
Social Security/Disability
Personal Use
Transfer
Insurance
Other: _____

I understand that the information in my health record may include information about my history, diagnoses and/or treatment. I authorize the disclosure of this specific information listed above. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect information. I recognize these Films/Disc/Reports are the property of Ocean Medical Imaging and they are legally responsible for this permanent record. Your signature allows us to release medical information to the parties designated above for one year.

_____

Patient/Recipients Name (print) (signature)

_____

Phone Number

_____

Witness