Adventist HealthCare Imaging

THE GEORGE WASHINGTON UNIVERSITY MEDICAL FACULTY ASSOCIATES MFA

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

MRN: _____

I authorize Adventist HealthCare Imaging to release information from my medical record.

❑ Self ❑ Mail as Specified ❑ Fax as Specified

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Attention (Required):

Information to be released:

Medical reports for the following dates: _____ to _____

Medical reports related to the following condition and treatment: _____

_____

If a patient is a minor, incompetent or unable to give consent, please complete.

I certify that the above patient is unable to give consent because: _____

_____ and that I am authorized to consent for him/her.

Signature: _____ Date: _____

Printed Name: _____

PSS: _____ Date: _____

Please call 301-590-8999 for information on how to return completed form.