3712 W. 7th Street Fort Worth, TX 76107
Phone: 817-377-3800
Fax: 817-377-3801

Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Previous Name(s): _____ SS#: _____

I request and authorize Monticello Diagnostic Imaging to receive healthcare information on the above named patient from:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

This request and authorization applied to:

❑ MRI Report
❑ CT Report
❑ X-Ray Report
❑ Images (Film/CD)

❑ Healthcare information relating to the following treatment, condition, or dates:

_____

❑ All healthcare information.

❑ Other:

Please provide all indicated healthcare information to Monticello Diagnostic Imaging.

Patient Signature: _____ Date: _____

Monticello Diagnostic Imaging Representative: _____

Date: _____