Authorization For Release Of Medical Record Information

Lifetest Medical Record# _____

I,: _____, *(please print clearly)*
LAST FIRST MI

authorize LIFETEST IMAGING CENTER, located at 1140 Hammond Drive; Bldg I, Suite 9120, Atlanta, Ga 30328, for the Date of Service of _____ to provide:

☐ **A WRITTEN COPY OF MY SCAN TO MYSELF at the address provided below**

_____
Street Address

_____
City *State* *Zip*

☐ **A COPY OF MY SCAN(s) IMAGES ON CD** (additional charges will apply for this option).

➢ Please Specify the Requested CD Images Below:

☐ Coronary (Heart) ☐ Lungs ☐ Heart/Lungs

☐ Abdominal/Pelvis ☐ Heart/Lungs/Abdomen/Pelvis

☐ Virtual Colonography

If you would like anyone other than your referring physician to obtain a copy, include their address:

C/O: _____

_____

_____

_____ _____
(*patient signature*) DATE

_____ _____
(witness) DATE