



Release of Information
(Please Print)

Patient Name _____ Date of Birth _____

Release records to: **Doctors Imaging Services**
4204 Teuton Street
Metairie, La. 70006
Fax 504-883-3555

Facility _____ Procedure _____ Date performed _____

Information requested:

- X-Ray & Reports Operative Report Lab Reports
- X-Ray Films/CD Pathology Report History/Physical
- Consultation Report

I understand that my medical record may also include information on diagnosis/treatment related to psychiatric or psychological conditions, drug and/ or alcohol abuse, immune deficiency syndrome (AIDS), and/ or HIV status.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____

I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released.

Signature of Patient/Legal Representative _____ Date _____
Relationship to Patient _____