University Diagnostic Institute Winter Park

Center for Advanced Medical Diagnosis

OUTSIDE FILMS RELEASE

We need to know if you have had any previous studies done to the area we are scanning today. Our radiologist requires that we have these to compare to the study you are having done. To assist us in obtaining these studies we need your permission, please complete this release.

Patient's Name:_____

Social Security#:_____Date of Birth:_____

Name of Center or Hospital where scans were performed:

_____

Type of Films:_____Date of Service:_____

I authorize the above center or hospital to release my films and reports to:

University Diagnostic Institute Winter Park
111 N. Lakemont Avenue
Winter Park, FL 32792
Phone# (407) 975-3315

*****Please fax reports to (407) 691-0316*****

Signed:_____**Date:**_____