To receive your medical record(s), please complete the following steps in their entirety:

1. Fill out each section of the "Authorization to Medical Records" form.
2. Submit via fax or email

Fax: Please fax the completed "Authorization to Release Protected Health Information" and a photocopy of your valid ID to 888-398-2921. All requests will be expedited as quickly as possible.

Email: Please email the completed "Authorization to Release Protected Health Information" and a photocopy of your valid ID to records@precisemri.com.

To prevent delays, please make sure the form the is filled out in its entirety. A team member will reach out via phone if additional information is needed.

Authorization To Release Medical Records

Please fill out each section below.

Patient Name: ____ MRN:__________

Date of Birth: ______________________________Social Security Number: XXX-XX- ___ ___ __

Alias/Maiden Name(s):______________________________ Phone: ______________

My Records to Release: (Please check the exam(s) you are requesting reports/images for.)

All medical records | MRI | PET
CT | X-Ray | Dexa/Bone
Densitometry | Mammogram | Nuclear Medicine
Ultrasound
Other: ____

Please provide a description of the exam(s) you want to us to share (date, exam, body part):

____

Select delivery type: Reports CD with my images

Please select your preferred method of delivery:

Fax to: ________________________________ Attn: ________________________

Mail to:____

Email to: ____

I authorize Precise Imaging to share my protected health information to the following individual(s):

Name: ____________________________________ Relationship: _______________

Name: ____________________________________ Relationship: _______________

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state privacy laws. I understand this authorization is voluntary. Unless otherwise revoked, this authorization will expire 1 year from the date of signature. You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to records@precisemri.com

____ ______________________

Patient or Authorized Representative Signature | Date of Signature

____ ______________________

Ful Name of Patient or Authorized Representative | Relationship to Patient