

Battlefield Imaging
4700 Battlefield Pkwy
Suite 100
Ringgold, GA 30736
(706)806-0170

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND FILMS

Patient Name: _____

Date of Birth: _____

To/Person or Institution: _____

Address: _____

City: _____ State: _____ ZIP: _____

CC: _____

To: Battlefield Imaging Center

I, the undersigned, hereby authorize Battlefield Imaging Center to furnish to the above named medical care provider at the above address, to entities involved in billing and collection, and may be requested regarding my past or present physical condition, treatment rendered, and diagnostic tests performed and to allow them or any physician appointed by them to examine and copy any and all bills, reports, records, and any films, or computer record of any test taken of me. I also understand that this authorization is subject to revocation/withdrawal by me at any time in writing to this medical record contact person at this site except to the extent that action has already been taken to release this information. This authorization shall remain valid unless revoked but will expire in one year after signing. I have the right to inspect a copy of the health information to be released and if I do not sign this authorization, Battlefield Imaging Center will not release my health information. Battlefield Imaging Center will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

ASSIGNMENT OF BENEFITS

In consideration of services rendered at Battlefield Imaging Center, I hereby assign and authorize direct payment to Battlefield Imaging Center of any insurance, health plan, third party benefits, Medicare, or Medicaid benefits otherwise payable to me or on my behalf for these services.

Any copy of this authorization shall be considered as valid as the original.

Signature of Patient or Legal Guardian/Representative

Date

Witness