AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I hereby acknowledge the receipt of Molecular Imaging "Notice of Privacy Practices"

Signature of Patient

Date: Witness:

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Molecular Imaging and/or its designees to provide treatment and/or examination and release **and obtain any previous exams or reports** pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjuster, or attorney, if applicable in this case.

Signature of Patient

Date: Witness:

Signature Authorization (*if needed*) - Complete this portion if you will send a specific individual to pick up your records. Please note, Molecular Imaging will automatically send your report to the referring physician once final.

Patient hereby authorizes the following individual to PICK-UP records:

Name: Relationship to Patient:

Comments

(Authorized Representative's photo ID must be verified upon pick-up)

Patient/Guardian Signature: Date:
(Required)

Expiration Date for PICK-UP Authorization: ________________
If expiration date is not written, it CANNOT exceed a period of more than one year from signature date.