GAINESVILLE HIGH FIELD MRI
AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT

** Please tell us with whom we ***may*** discuss your protected health information:

(Example: spouse (name), children (name(s)), other relatives (name(s)), friends or caregivers (name(s))

Name: _____Relationship:_____

Name: _____Relationship:_____

Name: _____Relationship:_____

Please tell us with whom we ***may not* discuss your health information:

_____

_____

_____

I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation.

_____ _____
Patient/Guardian Signature Date

_____
Print name of Person Signing

**Expires one year from date of signature

**If other than the patient (Patient Name) _____ is signing, are you the legal guardian, custodian or have power of Attorney for this patient, for treatment, payment or healthcare operations? _____ Yes _____ No