Please complete only marked (*) Information, and sign bottom of form.

SIRA Imaging Center, LLC
500 Landmark Avenue
Bloomington, Indiana 47403
812-333-7676
Fax: 812-333-7689

Authorization for Release of Medical Records

*Name of Patient_____*Date of Birth_____

*Address of Patient_____

*Social Security #_____*Telephone #_____

Please Complete-Name and Address of Party Releasing Records:

_____

_____

Please Complete-Name and Address of Party Receiving Records:

_____

_____

Please Indicate-Purpose of Releasing Records:

_____Permanent Transfer _____Medical History to Other Physician

_____Other:_____

Description of Information to be Released:

_____All Medical Records _____Records from specific date(s)

Dates of service:_____

*_____ *_____

Signature of patient or Legal Representative Date