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5120 Bayou Blvd., Suite 9
Pensacola, FL 32503
850.476.1161 Fax 850.476.3575

417 Racetrack Rd., NW Suite C
Ft. Walton Beach, FL 32547
850.862.1161 Fax 850.863.2431

www.awimaging.com

RELEASE OF INFORMATION

PURPOSE: To establish those individuals with whom you allow Angel Williamson Imaging Center to share your personal protected health information. You may revoke release of information to any of the persons listed at any time.

Patient Name: ____ Date of Birth: __________________

I authorize Angel Williamson Imaging Center to share my Protected Health Information (PHI) with the following individuals.

	Name	Relationship to Patient	Phone Number
1.	____________________	_______________________	___________________
2.	____________________	_______________________	___________________
3.	____________________	_______________________	___________________
4.	____________________	_______________________	___________________
5.	____________________	_______________________	___________________

Comments:

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Patient's Signature Date

cw 08.10.12
Revised: 06.15.15cw
Review: 06.15.15