ADVANCED SHORE IMAGING ASSOCIATES
Affiliate of Shore Health Enterprises

Diagnostic Study Release

Pick Up Date_____
Prepared By_____

I do hereby authorize Advanced Shore Imaging to disclose/request information from my medical record relating to my diagnostic study. I understand that this consent will serve as a complete release of liability to Advanced Shore Imaging and its employees for the release of information/films/CD.

I authorize Advanced Shore Imaging to release/request:

- ☐ **Copies of my reports**
- ☐ **CD of my diagnostic study**
- ☐ **Films of my diagnostic study**
- ☐ **Images of my diagnostic study printed On paper**

Exam type and/or dates_____

Released to:_____

Patient Name_____MR# _____

DOB_____

_____ _____
Patient Signature Date

Witness_____
(released by)
*** **Ask the patient or representative for ID.**