CereScan

Authorization to Release/Obtain Patient Information

Patient Name:	**Date of Birth:**
Obtain from ☐ **Release to** ☐ (check one) **Name:** **Address:** **City/ST/Zip:** **Phone:** **Fax:**	**Obtain from** ☐ **Release to** ☐ (check one) **CereScan** 991 SouthPark Drive, Suite 200 Littleton, CO 80120 **Phone** (866) 722-4806 **Fax** (833) 299-2501

How would you like these records released? (check one)

Mail ☐ **Fax** ☐ **E-mail** ☐ **@**

Please check the information to be released. (check all that apply)

- ☐ **Report and images**
- ☐ **Appointment information**
- ☐ **Demographic information, including Patient Billing Information**
- ☐ **Information regarding neurological/psychological/psychiatric conditions**
- ☐ **Other:**

AUTHORIZATION: I certify I have signed this request voluntarily, without any form of pressure or coercion being placed upon me by anyone. I hereby release both of the above parties from any liability which may result from this exchange of information. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. **This consent will automatically expire one year after the date of signing unless otherwise indicated.**

Signature of Patient or Legal Guardian **Date**

Signature of Patient (if Patient is a Minor Child of At Least 14 Years Old or Older) **Date**