# Medical Imaging Release Form

By signing this form, I authorize Oneida Medical Imaging Center to release confidential health information about me. Releasing a copy of my medical imaging/reports of my protected health information to the physician/person/facility/entity listed below.

Patient Name:_____

Date of Birth:_____

Release my protected health information to the following:

Name:_____

Address:_____

City, State, Zip Code:_____

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Patient Name:_____

Patient Signature:_____

E-mail Address:_____