ST. THOMAS RADIOLOGY ASSOCIATES

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Today's Date: _____

To: St. Thomas Radiology Associates, LLC
Paragon Medical Building, Suite 103
9149 Estate Thomas
St. Thomas, VI 00802
Fax #: (340) 776-0228
Phone #: (340) 774-0265

Requesting Physician: _____

I, _____ , hereby authorize the release of:
Print Patient Name

PLEASE CHECK BELOW

_____ All Medical Records (REPORTS)
_____ OR if specific dates and studies, please specify _____
_____

_____ All PACS Images
_____ OR if specific dates and studies, please specify _____
_____

_____ Temporary PACS Images access (no more than 30 days)

Date of Service: _____
Study: _____

Patient's Signature: _____ Date of Birth: _____

Mailing Address: _____
_____
_____