



REGIONAL IMAGING & THERAPEUTIC RADIOLOGY SERVICES, PC.

360 Bard Avenue • Staten Island, New York • 10310-0108 • (718) 876-2023 • Fax (718) 876-4524

Patient Name _____

Date of Birth _____

Medical Release Form for Release of Confidential Records

Pathology _____

Lab Results _____

Test Results _____

Miscellaneous _____

I hereby authorize release of the above to Regional Radiology, 360 Bard Avenue, Staten Island, New York 10310 or Facsimile (718) 876-4524.

Signed _____

Witness _____