

**OPEN MRI CENTERS OF GEORGIA
AUTHORIZATION FOR RELEASE OF INFORMATION**

PLEASE PRINT

Restrictions:

** I request the following restriction to the use of disclosure of my health information:

**Please tell us with whom we may discuss your protected health information:
(Example: spouse (name), children (name(s)), other relatives (name(s)), friends or
caregivers (names):

I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do, it won't have any effect on any actions they took prior to receiving the revocation.

Patient/Guardian Signature

Date

Print Name of Person Signing

*If other than the patient (Patient Name) _____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient for treatment, payment or healthcare operations? _____ Yes _____ No