Grossman Imaging Centers
Community Memorial Health System

Irwin Grossman, M.D. • Medical Director

RECORDS RELEASE AUTHORIZATION

Date:_____

I,_____hereby authorize and request you to release my

Films: MRI X-Ray CT Ultrasound

Report: MRI X-Ray CT Ultrasound

In your possession concerning my illness to:

Name_____

Address_____

City/State_____

Patient Signature:_____

Date
Signed:_____Witness:_____

Patient #:_____

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