Syed Akbar, MD
Javwaud Zafar, MD
Imran Qureshi, MD
John Doumanian, MD
Robert Palmer, MD
Mohsen Anwar, DO

2000 Ogden Avenue | Aurora, IL 60504
Phone: (630)898-4515 | Fax: (630)978-6805 | www.viradiology.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #:_____

I request and authorize _____
to release healthcare information of the patient named above to:

Valley Imaging Consultants, LLC.
2000 Ogden Avenue Aurora, IL 60504
Phone:(630)898-4515 / (630)978-6805

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

_____

○ All healthcare information ○ Other

_____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

○ Yes ○ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

○ Yes ○ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date signed: _____