

McLAREN IMAGING CENTER  
501 S. Ballenger Hwy., Suite B • Flint, MI 48532  
(810) 342-4800

**AUTHORIZATION TO RELEASE RADIOLOGY RECORDS**

To: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

**To Radiology Records:**

I authorize you to forward my films and reports to McLaren Imaging Center.  
Thank you.

Signed: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Last Exam Date: \_\_\_\_\_

Please mail to: McLaren Imaging Center  
501 S. Ballenger Hwy., Suite B  
Flint, MI 48532  
Ph: (810) 342-4800

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RADIOLOGY RECORDS**

M-34584 (11/07)



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PT.

MR./RM.

DR.