THE MRI CENTER
www.TheMRICenterMS.com
Fax: 228-396-3550

Cedar Lake Office
Phone: 228-354-0251

East Lake Office
Phone: 228-447-4MRI (4674)

Name: _____ **Age:**_____

MRN: _____ **Sex:** _____

DOS: ____/____/_____ **DOB:** ____/____/_____

To: Hospital / Clinic / Doctor: _____

Address: _____

City, State, and Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Original Images on CD are preferred when available and should be mailed to the address below:

- ☐ NM: _____
- ☐ X-Ray: _____
- ☐ Ultrasound: _____
- ☐ Mammogram: _____
- ☐ MRI: _____
- ☐ CT: _____
- ☐ Report(s)
- ☐ Report(s) only. **No images needed.**

THE MRI CENTER

Cedar Lake Office
1720-C Medical Park Dr.
Biloxi, MS 39532

East Lake Office
6300-B East Lake Blvd.
Gautier, MS 39565

I hereby authorize the release of medical information for diagnostic evaluation and comparison to The MRI Center and the Interpreting Radiologists Practices. I further authorize the acceptance of a copy, facsimile, or other electronic image of this form bearing my signature to be used for purposes of releasing the information as instructed above. I acknowledge that The MRI Center and the Interpreting Radiologists Practices are not responsible for lost films or films damaged during shipment to or from the facilities. This authorization will expire 90 days from the date noted above.

_____
Patient Signature

_____ _____-_____-_____
Patient Name **Social Security Number**

_____ _____/_____/_____
Address **Date of Birth**

_____
City, State, Zip

_____ _____
Witness Signature **Witness (Print Name)**