MEDICAL RELEASE AUTHORIZATION FORM

TO: St. Thomas Radiology Associates, LLC
9149 Estate Thomas
Paragon Medical Building, Suite 103
St. Thomas, VI 00802

I, ____ hereby authorize
(print patient's name)

the release of my Medical Records and/or films to______________________________.

______________________________	________________________________
Date of Request	Patient's Signature
______________________________	________________________________
Witness	Address
______________________________	________________________________
Date	City, State, Zip Code