

**LOCATION:** \_\_\_\_\_

**Bio-Magnetic Resonance, Inc.**  
30781 Stephenson Highway  
**MADISON HEIGHTS, MI 48071**  
(248) 585-5115  
FAX (248) 585-0234

**The Imaging Center**  
15670 Southfield Road  
**ALLEN PARK, MI 48101**  
(313) 294-2897  
FAX (313) 294-2915

**Bio-Magnetic Resonance, Inc.**  
25100 Kelly Road  
**ROSEVILLE, MI 48066**  
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FAX (586) 445-4902

**Biomagnetic Imaging Center**  
960 River Centre Drive  
**PORT HURON, MI 48060**  
(810) 966-8523  
FAX (810) 966-5056

**The Imaging Center**  
4447 Talmadge, Suite H  
**TOLEDO, OH 43623**  
(888) 674-8653  
FAX (888) 674-8650

**(888) MRI-TODAY**  
**(674-8632)**  
www.biomagmri.com

**AUTHORIZATION  
FOR RELEASE OF HEALTH INFORMATION**

I, \_\_\_\_\_, HEREBY  
(Patient's Full Name Printed)

AUTHORIZE BIO-MAGNETIC MRI/MRA IMAGING CENTERS, TO OBTAIN ANY AND ALL MEDICAL, LEGAL, AND INSURANCE RECORDS NECESSARY TO FACILITATE PAYMENT FOR SERVICES RENDERED. THIS INCLUDES BUT IS NOT LIMITED TO ACCESS TO AUTO INSURANCE CLAIM FILE INFORMATION, ATTORNEY LIEN INFORMATION, AS WELL AS PERSONAL INSURANCE INFORMATION FROM OTHER HEALTH CARE PROVIDERS NEEDED TO RESOLVE COVERAGE AND PAYMENT DISPUTES.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_  
(Patient or Representative)

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_