SOUTHERN TIER IMAGING
FAX AUTHORIZATION FOR MRI RESULTS

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PHYSICIAN(S) NAME(S):

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PHYSICIAN'S SIGNATURE:____

PLEASE RETURN THIS COMPLETED FORM (BY FAX OR MAIL) TO:

SHERI STORRS
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SOUTHERN TIER IMAGING
A DIVISION OF PARK AVENUE ASSOCIATES IN RADIOLOGY, P.C.
32 - 36 HARRISON STREET
JOHNSON CITY, NY 13790
PHONE#: (607)729-1999 FAX#: (607)729-0031