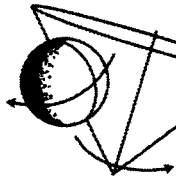


Carlsbad Imaging Center

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Imperial Radiology

2407 Marshall Ave., Ste. A
Imperial, CA 92251
P (760) 545-0340 F (760) 545-0341
www.imperialcountyradiology.com

Medical Records Release

I hereby authorize Carlsbad Imaging Center and/or Imperial Radiology **to release** my imaging study reports and/or images to the following :

- _____ 1.) **facility and/or physician(s) via fax and/or mail** (see written physicians below)
- _____ 2.) **to myself, the patient, via mail only** (see address below)
→ *Exceptional cases only: when a patient is physically unable to come into the office*
- _____ 3.) **to a family member or friend** (to be picked up in the imaging office)
→ *A picture ID will be used to confirm their name and DOB*

Name (last, first) _____ DOB _____ Relation _____

I hereby authorize Carlsbad Imaging Center and/or Imperial Radiology **to mail** my imaging study reports and/or images to my home address on file or address written below, and/or an authorized doctor's office named below; *I _____ understand and I am aware that by requesting my results to be mailed to my home address or a doctor's office may be breaching HIPPA privacy laws and that my personal records being mailed might not remain confidential.*

My Rights: I understand that unless revoked, this authorization is valid from the date of signing and will remain valid until revoked. I understand that I may revoke this authorization in writing or in person at the imaging center at any time except to the extent disclosure has already been made in accordance with this document. I understand that I do not have to sign an authorization as a condition for receiving treatment or health care benefits (treatment, payment or enrollment). I have read the above Authorization to Release Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Name: _____

Patient Signature: _____ Date: _____

Patient's Guardian Signature: _____ Date: _____

Physician Name 1. _____ 2. _____

Physician Phone 1. _____ 2. _____

Physician Fax 1. _____ 2. _____

Patient mailing address _____