Carlsbad Imaging Center
6010 Hidden Valley Rd. #125
Carlsbad, CA 92011
phone: (760)730-3536 fax: (760)720-4833
www.carlsbadimaging.com

Imperial Radiology
2407 Marshall Avenue, Suite A
Imperial, CA 92251
phone: (760)545-0340 fax: (760)545-0341
www.imperialcountyradiology.com

Medical Records Release

Patient Name _____DOB_____Relation_____

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 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*

If you selected option #1 or #2:
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: _____

Patient mailing address_____

Physician Name	**1.**_____	**2.**_____
Physician Phone	**1.**_____	**2.**_____
Physician Fax	**1.**_____	**2.**_____