



1229 Madison Street, 9th Floor Seattle, WA 98104 206-292-7744 206-292-6375 (fax)

## **Medical Records Request**

I,	, hereby authorize Radia to disclose the health information of:	
		//
Name of Patient (please print)	Medical Record Number	Date of Birth
Information to be sent to:  Self	f OR	
Name of recipient:		
Address:		
City, State, Zip:	Phone: ( )	
Health Information to be Disclose	e <u>d:</u>	
Radiology Report(s) Radiol	logy Image(s)	
Exam Type(s):		
Date(s) of Service:		
Please chase chase of the proof	ental illness, or psychiatric treatment unless specifically neck only if you do NOT want this information releated liagnosis Sexually Transmitted Disease ting Mental health or Psychiatric diagnosis.  Alth information is voluntary. I do not need to sign this or desire to complete/sign this form.  Alt any time in writing to the facility releasing information to the terms of this authorization, the informations with it the potential for further release and distributions with it the potential for further release and distributions from the representative processing the authorization from the date signed below unless another date of days from the date signed below unless another date of corization is valid for 90 days from the date signed.	s/treatment s for treatment. I may still obtain ion. I understand that once ation cannot be recalled. bution that may not be protected rization. or event is entered here:
Signature:		Date:/
If other than Patient, indicate relationsh (Guardian, Authorized Representative:	nip to Patient: Please provide documentation to confirm authority to	sign on behalf of patient)
CD/Films Created By		
Correct Images/Records Verified By		
Delivered to Patient/ID Verified By	Date	