MEDICAL RECORDS RELEASE AUTHORIZATION AND/OR DIGITAL IMAGE (CD) REQUEST

DO NOT RELEASE TO ANY OTHER FACILITY WITHOUT PRIOR AUTHROIZATION

DATE: __/___/_____

PATIENT NAME: _____

DATE OF BIRTH: __/___/_____

TYPE OF EXAM (e.g. Chest X-ray, MRI Brain, etc.)

_____

DATE OF EXAM(S)

_____

REQUESTING (CIRCLE):	WRITTEN-REPORT	*CD-OF-IMAGES

FROM:

*Nominal charge may apply

SOLANO DIAGNOSTICS IMAGING: FAIRFIELD/VACAVILLE, CA

(TEL) 707-646-4646 (FAX) 707-646-4949

_____

PATIENT'S SIGNATURE FOR RELEASE (If guardian, print your name::_____)

☐ For Personal Records or Legal Purposes

☐ For Medical Provider (Please Complete the Following)

TO: _____

_____

_____

ATTN: _____

PHONE: _____

FAX: _____

SDI USE ONLY:

ACCESSION NUMBER OF EXAM: _____

PATIENT MRN: _____

☐ ID

RELEASED BY: _____

Revision Date: 04/24/2016