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Olympia, WA 98506-5075
Phone (360) 493-4646
Fax (360) 493-4614
ssrecords@radiax.com

Authorization to Release Medical Information

Please complete the following information. Please print clearly.

***Patient Name**: ____ ***DOB**: _______________

☐ **Send to:**
Name/Organization:____

Address: ____

City: ____ **State:** ___________ **Zip:** _______________

Phone______________________________ **Fax #**____

***Important Notice* : Personal information released via e-mail is encrypted**.

☐ **E-Mail (Report Only): Email:** ____

By signing this form, you authorize **unencrypted** emails to the email address you provided.

☐ **Pick Up** **or** ☐ **Mail**

Information to be disclosed *(please check)*:

☐ **Radiology Report Only** ☐ **Both Images and Report**

Dates(s) of Service: ________________ **-** ________________ **Notes:** ________________________

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Patient Rights:

- I may revoke this authorization at any time in writing to the facility releasing information. I understand that once information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release and distribution that may not be protected by confidentiality laws.
- I can request a copy of this authorization from the representative processing the authorization.
- This authorization will expire 90 days from the date signed below unless another date or event is entered here: ______________________________________. Exception: If information is released to an employer or financial institution, this authorization is valid for 90 days from the date signed.

***Patient Signature**: ____ **Date**: ______________

2023