



3417 Ensign Rd NE
Olympia, WA 98506-5075
Phone (360) 493-4646
Fax (360) 493-4614
southsoundradiology.com
ssrcourier@radiax.com

Authorization to Release Medical Information

Please complete the following information. Please print clearly.

*Patient Name: _____ *DOB: _____

Please have my information ready for (please circle): Pick up E-Mail (report only)

Send to:

Name of Recipient: _____

Address: _____

City: _____ State: _____ Zip: _____

****Important Notice:** Any personal medical information that is released via **E-mail is unsecure**. I authorize my information to be sent to me via email (**initial here**) _____.

Email: _____

Phone _____ Fax # _____

Information to be disclosed (please circle):

Radiology Report

Radiology Images

Both Images and Report

Exam Type (please circle): MRI CT ULTRASOUND MAMMOGRAM X-RAY DEXA

Part(s) of Body: _____

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: _____

Please Fax to: (360) 493-4614