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

Authorization to Release Medical Information

Please complete the following information. Please print clearly.

○ **Verified Patient/Guardian ID (**Driver's License, Military ID or Photo ID) Office use only

***Patient Name**: ______________________ ***DOB**: __________

Mailing Address: ______________________

City: __________ **State:** __________ **Zip:** __________

Telephone: ______________________

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

***Part(s) of Body**: ______________________

I would like a copy of my (*Please Circle*): **Billing Images Reports Images & Reports**

○ **Pick up** ○ **Mail to my clinician** ○ **Mail to me** ○ **Mail to my attorney**

Clinician or Facility Name: ______________________

Clinician Address: ______________________

City: __________ **State:** __________ **Zip:** __________

Clinician Fax #: ______________________

NOTES ______________________

***Patient Signature**: ______________________**Date**: __________

Please Fax to: (360) 493-4614

Form revised 11/15/2017