SouthSound RADIOLOGY

3417 Ensign Rd NE
Olympia, WA 98506-5075
Phone (360) 493-4646
Fax (360) 493-4614

Authorization to Release Medical Information

Please complete the following information. Please print clearly.

○ **Verified Patient/Guardian ID**

***Patient Name**: _____ ***DOB**: _____

Mailing Address: _____

_____

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*): **Images Reports Images & Reports**

○ **I will pick up** ○ **Please mail to me** ○ **Please mail to my clinician**

Clinician or Facility Name: _____

Clinician Address: _____

_____

Clinician Fax #: _____

NOTES: _____

_____

***Patient Signature**: _____ **Date**: _____

Please Fax to: (360) 493-4614