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

Authorization to Release Medical Information

Please complete the following information. Please print clearly.

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

☐ **Mail to:**
Name/Organization:_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone_____ **Fax #**_____

☐ **Pick Up in Office**

☐ **E-Mail (Report Only):** Consent to unencrypted email communications: By checking this box, you permit South Sound Radiology to send unencrypted emails to the email address below related to your request. You acknowledge the risk that unencrypted emails may not keep your information safe and raise the risk of a third party accessing it. South Sound Radiology is not responsible for unauthorized access to unencrypted emails sent by South Sound Radiology.

Email: _____
_____

Information to be disclosed *(please check)*:

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

Dates(s) of Service: _____ - _____ **Notes:** _____
_____

*All requests can take up to 3-4 business days to be completed. *

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**: _____