



3417 Ensign Rd NE  
Olympia, WA 98506-5075  
Phone (360) 493-4646  
Fax (360) 493-4614  
[ssrcourier@radiax.com](mailto: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 person/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**\*Important Notice** : Personal information released via e-mail is encrypted. I authorize my information to be sent **unencrypted** (initial here) \_\_\_\_\_.

Email: \_\_\_\_\_

Phone \_\_\_\_\_ Fax # \_\_\_\_\_

Information to be disclosed (please circle):

**Radiology Report Only**

**Both Images and Report**

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

Dates(s) of Service: \_\_\_\_\_ - \_\_\_\_\_ Notes: \_\_\_\_\_

### 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: \_\_\_\_\_