MT BAKER IMAGING and NORTHWEST RADIOLOGISTS

Authorization to Release Patient Health Information

Medical Records/Imaging Library
Phone: (360) 788-9014 Fax: (888) 329-6768

Patient Name: _____ Date of Birth: _____

I hereby authorize Mt. Baker Imaging/Northwest Radiologists to release my medical records as specified below:

Destination: (Facility/Provider/Individual):

Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State_____ Zip: _____

Information to be released -exam(s) including body parts and date range:

_____

_____

Purpose of Release (check all that apply):

☐ Continuing care/Medical Purpose ☐ Report(s) only

☐ Copy of images for personal use: ☐ Other: _____

☐ CD

☐ Ambra –email address: _____

Format of Images (if applicable)

☐ Ambra (may not be available for all sites. Contact Film Library with questions)

☐ PACS electronic transfer (may not be available for all sites. Contact Film Library with questions)

☐ CD/DVD for a ☐ PC or ☐ Mac

☐ Mail to facility ☐ Mail to patient ☐ Patient transport -pick up date_____ (*picture ID required*)

Designee pick up –full name :_____(*picture ID required*)

_____ _____

Signature of Patient/Patient Representative **Date**