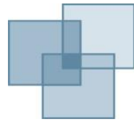

MT BAKER IMAGING and NORTHWEST RADIOLOGISTS

Authorization to Release Patient Health Information

Medical Records fax: (360) 788-9014
Imaging Library 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: ______________________
  - ☐ Ambra –email address: ____________________________

Format of Images (if ***applicable)***

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

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

____ ______________________

Signature of Patient/Patient Representative ***Date***