



Medical Imaging, P.A.
 9501 N. Oak Trafficway
 Kansas City, MO 64155-2256
 (816) 455-0661 (phone)
 (816) 455-3905 (fax)

Independence
 19000 E. Eastland Center Ct.
 Independence, MO 64055-7004
 (816) 876-2900 (phone)
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 Natasha Acosta, M.D.

Authorization to Release And / Or Receive Records

Are you releasing these records permanently to Medical Imaging? Yes__ No__

Patient Name: _____ Chart # _____

DOB: _____ Phone: _____

Address: _____

I hereby authorize Medical Imaging to:

- Release copies of billing or medical records to the following persons or entities
- Receive copies of medical records from the following persons or entities

The following information shall be obtained and/or released pursuant to this Authorization:

- Mammography film
- Radiology Report
- Pathology Report
- Operative Report
- Other (Specify)

Information may be released in writing, verbally, or by video, fax, photocopy, or microfilm.

I request that the above information be released for the following date(s) of service: _____

NOTICE TO PATIENT /PATIENT REPRESENTATIVE: If the recipient of the information disclosed pursuant to this Authorization is not a health care provider, health plan or healthcare clearinghouse, the information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy laws and regulations.

The information will be obtained and /or disclosed for the following reasons:

- AT THE REQUEST OF THE INDIVIDUAL (FOR COMPARISON)
- Other (Specify):

This authorization will expire 1 year from date of the signature below.

This Authorization may be revoked by notifying our Privacy Officer in writing at the following address:

Lissa Jones, Privacy Officer
Medical Imaging, Inc.
9501 N. Oak Trafficway, Suite 100
Kansas City, Missouri 64155

Note: Protected health information may already have been disclosed before the revocation is received. If so, the revocation will be effective as of the date by our Privacy Officer.

Patient Signature Date

Patient's Printed Name

This authorization is voluntary. A refusal to sign will not affect The patient's ability to obtain treatment, payment, or if applicable enrollment in a health plan or eligibility for benefits.

Requested By
PLEASE MAIL TO:
MEDICAL IMAGING-EASTLAND
19000 E. EASTLAND CENTER COURT, SUITE 100
INDEPENDENCE, MO 64055

PHONE: 816-876-2900
FAX: 816-876-2901