



**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:

**Tracy Wagner, Privacy Officer Medical Imaging**  
9501 N. Oak Trafficway  
Kansas City, MO 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**

\_\_\_\_\_  
**Requested By**

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.

**PLEASE MAIL TO:**

**MEDICAL IMAGING - North**  
9501 N Oak Trafficway  
Kansas City, MO 64155

**PHONE: 816-876-2800**  
**FAX: 816-876-2801**