

**AUTHORIZATION FOR RELEASE OF MEDICAL
INFORMATION FROM MINOR AND JAMES MEDICAL
IMAGING DEPARTMENT**

Patient MRN # :

X-Ray Number :

Name :

Date Of Birth :

Address :

City / State :

Zip Code :

Phone Number :

I REQUEST AND AUTHORIZE :

Name : MINOR & JAMES MEDICAL - IMAGING DEPARTMENT

Phone : 206.386.9699

Address : 515 MINOR AVE, SUITE 110

City/ State/ Zip : SEATTLE, WA 98104

TO RELEASE HEALTH CARE INFORMATION OF THE PATIENT NAMED ABOVE TO :

Name :

Phone :

Address :

City/ State/ Zip :

I. MY AUTHORIZATION

You may use or disclose the following healthcare information (Check all that apply)

Ultrasound Report Only CD Films

Mammograms MRI CT Nuclear Medicine X-ray Body Part: _____

Purpose or need for this information :

Legal Insurance Continuity Of Care Other _____

Please DO NOT release information on the following (unless required by law)

HIV (AIDS Virus) Psychiatric disorders / mental health

Sexually Transmitted Diseases Drug and /or alcohol use

II. MY RIGHTS

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment or enrollment). However, I do need to sign an authorization form:

* To take part in a research study

* To receive healthcare when the purpose is to create healthcare information for a third party.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I may revoke this authorization in writing to Minor & James Medical Imaging Department. If I did, it would not affect any actions already taken by Minor & James Medical based upon this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance.

This authorization expires in 90 days after the date it is signed. Possible film copying fee required.

Signature of patient or legally authorized representative

Date Signed

Printed name if signed on behalf of the patient

Date Faxed/Sent : _____

Name of sender : _____