SANTA FE IMAGING

Desert Rose Women's Center
AT SANTA FE IMAGING

FACILITY NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

NOTES: _____

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You are hereby authorized to furnish **CD IMAGES** and **REPORTS**
concerning my past and present condition to:

SANTA FE IMAGING, LLC
1640 HOSPITAL DRIVE
SANTA FE, NEW MEXICO 87505

I hereby release Santa Fe Imaging, LLC from all liability and all claims of any nature whatsoever pertaining to disclosure of information contained in these medical records.

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

PATIENT PHONE NUMBER: _____

EXAM REQUESTED: _____

_____

_____

_____ _____

PATIENT SIGNATURE DATE