1640 Hospital Drive, Santa Fe, NM 87505 • TEL: 505-983-9350
FAX Lines: Scheduling: 505-954-4253 • Med Records: 505-986-0859

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________ Date of Birth: ______________

Address: ______________________ ______________________ ______________________
Street and number / Apt — CITY — STATE & Zip CODE

Contact Phone Number(s): (_____) ______________ (_____) ______________

I request and authorize **Santa Fe Imaging, LLC** to release medical imaging records & reports to:

Name of person or facility ______________________________

☐ Hold for pick up When? ______________________________

☐ Mail to: Street Address: ______________________________

City: ______________ State: __________ Zip: __________

NOTE: If records are to be mailed or faxed, please attach a copy of your Driver's License or a picture ID.

Party receiving records is: ☐ My physician ☐ A Relative/friend w/ID ☐ Other - (describe): ______________

Release is requested for:

☐ All images and or reports in my SFI record jacket or in SFI's electronic records

☐ Images relating to the following exam date(s): ______________________________

☐ Reports relating to the following exam date(s): ______________________________

☐ Other (explain): ______________________________

IMPORTANT: FIRST COMPACT DISC (CD) WILL BE ISSUED AT NO CHARGE AND ANY ADDITIONAL SETS $5.00.

BY SIGNING THIS FORM, THE PATIENT OR PATIENT'S REPRESENTATIVE AUTHORIZES ***SANTA FE IMAGING, LLC*** TO DISCLOSE RECORDS OR OTHER INFORMATION TO THE PERSON OR ORGANIZATION DESIGNATED AND AGREES TO PAYMENT AS SPECIFIED ABOVE.

THIS AUTHORIZATION: *Remains in effect until specifically revoked.*

I hereby release **Santa Fe Imaging, LLC,** from all liability and claims of any type related to disclosure of the designated medical records to the party/parties designated above.

Patient Signature: ______________________________ Date: ______________

Authorized Representative Signature: ______________________________ Date: ______________