SANTA FE IMAGING

1640 Hospital Drive, Santa Fe, NM 87505 • TEL: 505-983-9350

Desert Rose Women's Center
AT SANTA FE IMAGING

FAX Lines: Scheduling: 505-954-4253
Med Records: 505-986-0859

Form can be completed online. However, in order to sign it must be printed. Once it is printed and signed, please send to IT_SUPPORT@santafeimaging.com

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 _____

☐ 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.

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

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

IMPORTANT: FIRST COMPACT DISC (CD) WILL BE ISSUED AT NO CHARGE AND ANY ADDITIONAL SETS $20.00.

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: _____