



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



**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 [MEDICALRECORDS@santafeimaging.com](mailto:MEDICALRECORDS@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: