MEDICAL RECORDS REQUEST

BELLINGHAM ADVANCED MEDICAL IMAGING

Patient First and Last Name: _____

Patient Date of Birth: _____/_____/_____

I request and authorize _____ to release health care information of the patient named above to **Bellingham Advanced Medical Imaging** for the purpose of: (check all that apply)

- ☐ Prior imaging of: _____
  - ☐ Disk ☐ Faxed Report ☐ Both
- ☐ Chart notes on: _____
- ☐ Blood work within the last two months: _____
- ☐ Surgery notes on: _____
- ☐ Other: _____

Patient Signature: _____ Date: _____/_____/_____

CONSENT OF GUARDIAN OR AUTHORIZED PERSON

Signature of Parent/Guardian: _____

Date: _____/_____/_____ Relationship to Patient: _____

DISCLAIMER: If a minor consented to health care without parental consent for his/her own treatments, then the minor must consent or release of health care information. Bellingham Advanced Medical Imaging is hereby released from all legal responsibility or liability for the release of the above-mentioned information. Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information. You are entitled to a copy of the authorization. You may revoke this authorization by a written request.

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