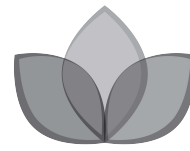


# AUTHORIZATION TO RELEASE RECORDS



**Women's  
Imaging  
Center**

Patient First and Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

I hereby request and authorize Women's Imaging Center release health care information of my imaging report(s) of the patient named above to the following entity or person:

Organization / Person Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

This request and authorization applies to the following: (please check all applicable boxes):

- All health care information
- Health care information relating to the following treatment, condition, or dates of treatment:  
\_\_\_\_\_
- Other: \_\_\_\_\_

Check any of the boxes which apply below. I specifically authorize the release of the following records:

- HIV/AIDS     Mental health     Sexually transmitted diseases     Drug and/or alcohol use

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## CONSENT OF GUARDIAN OR AUTHORIZED PERSON

First and Last Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**NOTICE:** Bellingham Advanced Medical Imaging is also pleased to provide complimentary copies of your health care information directly to your health care provider. Authorization becomes invalid ninety (90) days after this form was signed, or upon the expiration date of: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, whichever is earlier.

**DISCLAIMER:** If a minor consented to health care without parental consent for his/her own treatments, the minor must consent or release his/her own records. Bellingham Advanced Medical Imaging is hereby released from all legal responsibility of liability from 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 written request. If you have any questions about disclosure of your health information, please contact Bellingham Advanced Medical Imaging.

### FOR INTERNAL USE ONLY

Identification checked?

Staff Initials: \_\_\_\_\_

5.9.2018

### Women's Imaging Center

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