BEXAR IMAGING
A WellMed Company

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize BEXAR IMAGING to release radiological and or medical information {including, if any, psychiatric or psychological information, infections or contagious disease abuse information (including HIV/AIDS confidential information), and/or information about drug or alcohol abuse treatment} from the health records of:

Patient _____Date of Birth_____

Address_____

City _____State_____ Zip _____

DATE OF SERVICE_____

CT_____ MRI_____ DEXA_____ ULTRASOUND _____ X-RAY _____

MAMMO_____ If MMGs prior to 2011, last 4 digits / SSN: ___ ___ ___ ___

TO BE RELEASED TO: _____Mail____ Pick-Up____

ADDRESS: _____

ATTENTION: _____PHONE#:_____

Staff Taking Request_____Date of Request_____

PICK-UP

Patient Signature_____Date_____

Courier Name / Signature_____Date_____

GUARDIAN:

I acknowledge I have the patient's permission to request this information and understand that this consent automatically expires one hundred twenty (120) days from the date set forth above. The patient/guardian can revoke this authorization in writing at any time prior to the expiration date.

_____ _____

Guardian Signature Date

_____ _____

Relationship to Patient Reason patient is unable to sign