alinea | MEDICAL IMAGING

MEDICAL RELEASE

CONTACT: (909) 622-3166

Patient Name: _____ Date: _____

Address: _____ DOB: _____

City: _____ MRN#: _____

Phone: ( ) _____

CATEGORY	TYPE OF EXAM	DATE OF EXAM (MM/DD/YY)
☐ Breast Imaging		
☐ X-Rays		
☐ Ultrasound		
☐ Other		

IMAGE TYPE

☐ Images CD

☐ Printed Film

RELEASE OF MEDICAL RECORDS:

I hereby authorize Alinea Medical Imaging to release my films and reports to any requesting physician or medical facility providing my medical care for continuing treatment in my health care. This authorization will remain in effect for 1 year from the date of my signature.

X: _____ **Date:** _____

☐ Patient ☐ Other/Relationship: _____

WHERE SHOULD THESE RECORDS BE SENT?

Facility Name: _____

Address: _____

Phone: _____

Fax: _____