BACK BAY IMAGING

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Film Release Authorization

Patient Name _____ **Date of Birth** _____

I hereby authorize the release of my (check all that apply):

☐ CT ☐ MRI ☐ US ☐ MAMMO ☐ X-RAYS of: _____ images & reports to:

Back Bay Imaging, Inc.
301 Bayview Circle, Suite 105
Newport Beach, CA 92660
(949) 799-3000

_____ _____
SIGNATURE* DATE

*Patient or Patient Representative: Parent/Conservator/Guardian

NOTE: PLEASE SEND IMAGES ON CD IN DICOM FORMAT IF POSSIBLE

Facility where previous images were taken:

Facility _____ **Year Taken** _____

Street Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Fax** _____ **E-mail** _____

For WIC office use only:

Patient WIC# _____ **Images sent for:** ☐ YES ☐ NO _____ TECH INTLS.

Person contacted _____ **Date** _____

WIC contact person _____

Images will be: ☐ Mailed ☐ Delivery service ☐ Picked up by patient