BACK BAY IMAGING

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Authorization for Release of Medical Records

Patient _____ **DOB** _____
(PLEASE PRINT FULL NAME)

Type of Exam _____ **Date** _____

Send ☐ Images (CD) ☐ Reports

I hereby give Back Bay Imaging consent to release medical records to (Check one):

____ Self

____ Designated Representative: _____
PLEASE PRINT NAME OF PERSON PICKING UP RECORDS

NOTE: *If requesting release to self or designated representative, if not already provided, photo identification must be provided at time of picking up records (ie: driver's license, Student ID, passport, etc)*

Facility _____

Address _____

Phone _____ **Fax** _____

By signing below, you hereby authorize the release of medical records (images/reports)

_____ _____
SIGNATURE DATE