resolution imaging

Authorization for Release of Health Information

Attn: Medical Records
2428 SANTA MONICA BLVD. Lower Level
SANTA MONICA, CA 90404
Phone#: 310-526-2374

Fax#: 310-526-0392

PATIENT NAME: _____ DOB: _____

NAME OF FACILITY(S) (Records to be released from): _____
FAX NUMBER: _____
PHONE NUMBER: _____

REQUESTED EXAM(S) (to be released): _____

Notice of Patient Rights:

- **I understand this authorization is voluntary. If I refuse to sign this authorization my refusal will not affect my ability to obtain treatment.**
- **I may revoke this authorization at any time in writing and submit to the medical records department at the address listed above.**

Expiration of Authorization:

- **Without my written revocation, this authorization will automatically expire 12 months after the date of signing this form, unless otherwise revoked.**

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE: _____
DATE: _____

FORM COMPLETED BY: _____

STAT REQUEST… PLEASE FAX REPORT& DELIVER CD