Authorization for the Release of Medical Records

Professional Ultrasound Imaging

Please release the medical records of : ______________________________________

DOB: ______________ Dates of Service: From _____________ To: ___________ All θ

Please send the records to :

____

____

____

By my signature below, I authorize Professional Ultrasound Imaging to release my medical records to the address listed above. I understand that if the original films are included, Professional Ultrasound Imaging will no longer be responsible for the archiving of those films.

Please select one of the following:

θ I **do** want the original ultrasound films included. Initials:_________

θ I **do not** want the original ultrasound films included Initials: _________

____ ___________________

Client Signature Date

____

Printed Client Name

____ ___________________

Witness Date

____

Printed Witness Name

Professional Ultrasound Imaging
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