Authorization for Release of *Protected Health Information*
From An *Outside Organization*

Patient Name: **(Maiden/Other Name):**

Patient Date Of Birth: **Phone #:** **Fax #:**

Reason for Release: **Permanent Transfer** **For Comparison**

Provide detailed description (*required*):

Requesting:

Reports Only
CD & Report
Film, CD, & Report
Film & Report

For:

Mammography
Ultrasound
Fluoroscopy
PET
MRI
X-Ray
CT

Need by / Appointment Date:

Name of Facility / Person authorized release:

Address:

Phone #: **Fax #:**

I understand that this Authorization is effective for a period of *90 days from the date of signature*, unless otherwise specified below. **No time frame may exceed one year from the date of signature.** I understand I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized to release the information.

If applicable, specify any other expiration date / event here:

Signature of Patient ***Date of Signature*** ***Signature of Parent or Guardian***

Please Release Films / CDs to:
PENRAD Imaging, 3050 N Circle Dr. Colorado Springs, CO 80909

Phone: (719) 867-7962
Fax: (719) 867-7915