AUTHORIZATION FOR RELEASE OF MEDICAL IMAGES, REPORTS, AND MEDICAL RECORDS

Patient Name: Previous Name(If Different):
Date of Birth: Medical Records#:

Facility:	Date of Exam:
Address:	Type of Exam:

☐ CD only ☐ Films only ☐ Report Only
☐ CD and Report ☐ Films and Report ☐ CD Report and Films

☐ I hereby authorize you to release to Stockdale Radiology LLC or its representatives, the following medical images and/or records from the facility listed above.
Please send to the following address: Stockdale Radiology
4000 Empire Drive, Suite 100
Bakersfield, CA 93309

☐ I hereby authorize Stockdale Radiology, LLC to release the listed medical images and/or records to the facility listed above.

Mammography patients: If prior films are unobtainable, this exam will become your baseline.

The purpose of this request is for comparison to previous treatment/surgery/effectiveness or as comparison to recent procedure.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to: history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I understand that treatment or payment cannot be conditioned on my signing this authorization, except in certain circumstances such as for participation in research programs or authorization of the release of testing results for pre- employment purposes. I understand that I may revoke this authorization in writing at any time except to the extent

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that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee and for copies of my medical records.

This authorization will expire NINETY (90) days from the date of my signature unless I revoke the authorization, in writing, prior to that time.

Patient Signature or legally authorized representative :

Date:

OFFICAL USE ONLY:

☐ ID verified by VALID form of ID.
ID type:
ID number:

Applicable Fees:
Delivered directly to another medical facility: No Fee
Delivery to Patient or Third party not a provider: $15min charge plus delivery cost.

Revised 11/22/13

4000 Empire Drive, Suite 100, Bakersfield, CA 93314. Phone 661/631/8000 Fax 661/631/8005