via RADIOLOGY

Via Radiology-Meridian Pavilion
11011 Meridian Avenue N • Suite 101
Seattle, WA 98133
Phone: 206.306.1011
Fax: 206.306.1019

via VASCULAR

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name ______________________________ Date of Birth ______________

Social Security Number ______________________________ Medical Record Number ______________

- This authorization may be revoked in writing at any time except to the extent already relied upon, and will expire in 90 days unless previously revoked.
- You may inspect or receive a copy of the information being released.
- The information used or disclosed may be released by the recipient and no longer protected by Federal Privacy Rule.
- You may refuse to sign this authorization to release information and this will not affect your access to care.

Information to be released *FROM:*

I hereby authorize the following organization to release the medical information stated below from the patient's medical record:

❒ Via Radiology-Meridian Pavilion **OR**

❒ ______________________________ (Organization / Person)

______________________________ (Street Address)

______________________________ (City, State, Zip)

Information to be released *TO:*

❒ ______________________________ (Organization / Person)

______________________________ (Street Address)

______________________________ (City, State, Zip)

______________________________ (Telephone Number)

❒ Via Radiology-Meridian Pavilion

Purpose or reason for release of information **(required)**

❒ Requested by patient **OR:**

(Specify) ______________________________

Type of information (check all appropriate boxes):

	Dates of Service
❒ History / Treatment Summary	________
❒ Emergency Room Record	________
❒ Diagnostic Imaging Reports	________
❒ Lab Reports	________
❒ Any and all records	________
❒ Other ______________	________
❒ Other ______________	________

Specific Release:

Please Initial

This release [ ] MAY [ ] MAY NOT

Include specific information related to sexually transmitted diseases (including HIV), alcohol or drug abuse, and mental health / psychiatric treatment.

______________________________ ______________________________

Signature of Patient (or other responsible person) Date

______________________________ ______________________________

Relationship (if not patient) Signature of Witness