



Medical Record Authorization for Release or Request

Name: _____ Date: _____

Date of Birth: _____

Home phone: _____ Cell #: _____

Notes: _____

I request Oregon Advanced Imaging to release a copy of my CD, Report, to the following:

Name: _____

Address: _____

Need records by: _____

- Mail
- Fed Ex/UPS
- Pick-up at the following OAI imaging center _____

Please note: there may be an additional charge for copies, CDs, and mailing/handling.

Signature of Patient: _____ Date: _____

Sign and mail form back to:
Oregon Advanced Imaging, P.O. Box 1527, Medford, OR 97501. Attn: Records Request

For office use:

	MRN#: _____
	Assession #: _____
<input type="checkbox"/> CD <input type="checkbox"/> Report	
Shipping tracking # _____ (if using FedEx/UPS)	
Postage: _____ Handling fee: _____	
Total paid by patient: _____	

5/15/08