

CONSENT FOR RELEASE OF MEDICAL INFORMATION

DATE: _____

I hereby authorize _____ to convey to Oregon Advanced Imaging my x-ray/lab reports, films, chart notes, and records:

_____ / _____

_____ / _____

_____ / _____

PATIENT NAME: _____

DOB: ____ / ____ / ____

() -
Patient or Guardian Signature / Phone Number

Date

Please mail / fax to:

OREGON ADVANCED IMAGING
881 O'Hare Parkway
Medford, OR 97504

Fax: 541 608-0376

Ph: 541 608-0350