Oregon Advanced **IMAGING**

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: ______________________________

____

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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 97520. Attn: Records Request

For office use:

MRN#: ______________________________
Assession #: ______________________________

☐ CD ☐ Report

Shipping tracking # ______________________________ (if using FedEx/UPS)

Postage: ______________________________ Handling fee: ____________________

Total paid by patient: ______________________________

5/15/08