Authorization for Release of Medical Information

I authorize the San Diego Imaging facility/facilities indicated to the left *(please check the facility/facilities from which you are requesting information)* to release/disclose my medical imaging records, to include:

☐ Imaging/Procedure report(s) ☐ CD of Images

_____
Patient Last Name, First Name and Middle Initial

_____ (____)_____
Patient Date of Birth Patient Phone Number

_____
Patient Street Address

_____
Patient City, State, Zip

Information to be released for these dates of service:
_____ to _____

Records are to be released to:

☐ Me ☐ My Spouse (name): _____

☐ My child/parent (name): _____

☐ Other (name and address): _____

_____

☐ Doctor (name and address): _____

_____

Delivery Method:

☐ Pick-Up* / Date to be picked up_____

Location to be picked up (Please circle one)

Chula Vista Escondido Kearny Mesa Oceanside

**Please have person picking up medical records bring picture ID*

☐ Mail** / Address as indicated above (please circle one)

Patient Other Doctor

*** Please be certain complete address is listed above*

_____ _____
Patient Signature Date

☐
San Diego Imaging-Chula Vista
765 and 755 Medical Center Ct.
Chula Vista, CA 91911
T: (619) 397-6577
F: (619) 502-8585

☐
San Diego Imaging–Escondido
1955 Citracado Parkway, #100
Escondido, CA 92029
T: (760) 743-3873
F: (760) 743-3874

☐
San Diego Imaging-Kearny Mesa
7910 Frost Street, Suite 100
San Diego, CA 92123
T: (858) 634.5900
F: (858) 634-5990

☐
San Diego Imaging-Oceanside
3909 Waring Rd., Suites B&C
Oceanside, CA 92056
T: (760) 630-0014
F: (760) 630-0015

To be completed by SDI Staff:

*Jacket/MR #:*_____
Records prepared and verified by:
_____

*Date:*_____ *Time:*_____

Date Mailed: _____

SDI staff member name (ID verified and records released by):
_____

ID type/#: _____

Signature of person picking up records:
_____

*Date:*_____