OUTPATIENTRADIOLOGY
Focused on Care, Driven by Excellence

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:_____ DOB:_____

List any other name(s):_____

Address:_____ Phone:_____

I do hereby understand and consent to the release of confidential information in the custody of:

Outpatient Radiology
419 S Washington St, Ste 101
Casper WY 82601
Phone: 307/232-5014
Fax: 307/577-0443
E: medicalrecords@caspermedicalimaging.net

TO BE RELEASED TO: ☐

FROM: ☐

_____
Hospital/Facility/Person

_____

_____

_____
Address/City/State/Zip

Please check Images and/or Reports:
☐ Images ☐ Reports
Please check at least one:
☐ CT ☐ Ultrasound
☐ MRI ☐ X-Ray
☐ Mammogram ☐ DEXA
Last 3 Screenings.

Nuance PowerShare to Casper Medical Imaging – OPR

If patient is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the patient and the parent or legal guardian must sign.

I understand that I may revoke this authorization at any time, except to the extent that action, based on this authorization, has already been taken. This consent will expire automatically six months from date on which it was signed. Any disclosure of medical record information or protected health information (PHI) by the recipient(s) is prohibited by law.

Patient Signature: _____ Date:_____

Authorized Signature: _____ Date:_____

I affirm that the patient is deceased, that no other personal representative of his/her estate has been appointed, and that I am the patient's _____.

Signature:_____ Date:_____