Guam Radiology Consultants

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RELEASE OF MEDICAL RECORDS

I hereby authorize (Name of Facility) _____ to release an radiology exams (films or CD) and reports (CT Scan, Ultrasound, MRI , X-ray reports and etc…) or any progress notes and/or pathology reports to Guam Radiology Consultants for the course of my examination or treatment. A photocopy or faxed copy of this form will serve as an original.

This form, unless directed by me to be invalidated, shall remain effective for twelve (12) months from the date of my signature.

PRINT PATIENT'S NAME

_____
LAST NAME FIRST NAME MI

DATE OF BIRTH

_____
MONTH / DATE / YEAR

_____
PRINT NAME OF GUARDIAN OR LEGAL REPRESENTATIVE

_____
RELATIONSHIP TO PATIENT

_____
SIGNATURE

_____
TODAYS DATE