Authorization for Disclosure of Medical Records

Patient Identification: (fill in)	
Patient Name Used at Time of Treatment:	
Patient's Date of Birth:	
Patient's Phone Number:	

Records to be Disclosed *(check one)*

- All Medical Records held by Vancouver Radiologists Imaging Center
- Only specific Medical Records (indicate specific procedures, dates of service, etc.):

Authorization

I understand:
-That this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse and mental health conditions.
-That this authorization may be revoked in writing at any time. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization shall expire one (1) year from the date signed below.
-That any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.
- That Vancouver Radiologists Imaging Center may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.
I hereby release Vancouver Radiologists Imaging Center, its employees, officers, physicians, and affiliated entities from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Purpose of Disclosure *(check one)*

- **Transfer of care/Closing of practice**
- Other:

I hereby authorize Radia, Inc., P.S. and Vancouver Radiologists Imaging Center to disclose the medical records as indicated above to:

Name: ____

Address: ____

City, State: __________________________ **Zip code:** __________

______________	____	____________________
Date	**Signature of Patient or Patient Representative**	**Relationship to Patient**

***BEFORE* May 27, 2022**	***AFTER* May 27, 2022**
Please mail completed form to: **Vancouver Radiologists Imaging Center** **4816 A NE Thurston Way** **Vancouver, WA 98662** **Fax: 360-882-1007**	Please mail completed form to: **Radia, Inc., P.S.** **19020 33rd Avenue West, Suite 210** **Lynnwood, WA 98036** **Fax: 425-563-1501**

Office use:
Record Released By: ___________________________________ **Date:** ______________