Patient Record Release Authorization

To Whom It May Concern:

I hereby authorize STAT Imaging and its affiliates to release/obtain my radiograph(s), surgical report, and general office notes from/to:

Name_____ Address _____

Type of radiograph(s),surgical reports, or general office notes requested:_____

_____ ___/___/___
Patient/Guardian Signature Date

Notice of Privacy Practice/Patient Rights

A copy of the Notice of Privacy Practice from STAT Imaging concerning how the use of disclosure of protected health information will be handled by the practice is available to you as well as a copy of the Patients Bill of Right's.

_____☐ ACCEPT _____☐ DECLINE

_____ ___/___/___
Patient/Guardian Signature Date

Communication Authorization

STAT Imaging uses many methods of communication with our patients. Below are the methods in which you can expect to be contacted by STAT Imaging. Please check the methods in which you would like us to contact you by

____☐ Home Phone Number
____☐ Work Phone Number
____☐ Cellular Phone Number
____☐ Answering Machine/Voice Mail

_____ ___/___/___
Patient/Guardian Signature Date