CHESAPEAKE REGIONAL IMAGING CENTERS

RECORDS RELEASE AUTHORIZATION

TRANSFER FROM

_____
DOCTOR / HOSPITAL

_____
ADDRESS

_____
PHONE

_____
FAX

TRANSFER TO

Chesapeake Regional Imaging Centers

Phone: 757-671-8500
Fax: 757-333-0256

TO BE COMPLETED BY CHEASAPEAKE REGIONAL IMAGING STAFF

❑ REPORT ❑ CD ❑ FILM
❑ PICKED UP BY COURIER ❑ PICKED UP BY PATIENT ❑ MAIL TO MERIDIAN ❑ PLEASE FAX

I hereby authorize and request you to release my complete records in your possession concerning my illness and/or treatment.

Patient's Name: _____ DOB: _____

Address: _____

Type of exam: _____

Patient's Signature: _____ Date: _____