BROADWAY IMAGING CENTER

Medical Records Release

Patient Name:____________________ Date of Birth____________________

Street Address____

City____________________ State________ Zip Code:__________

Images Requested: | **Date of Services:**

- ❑ CT ____________________
- ❑ Mammography ____________________
- ❑ MRI ____________________
- ❑ Nuclear Medicine ____________________
- ❑ Ultrasound ____________________
- ❑ General X-Rays ____________________

Release to:

- ❑ Self
- ❑ Designee
- ❑ Other Facility

Name________________________________

Address________________________________

City________________ State________ Zip________

I authorize Broadway Imaging Center to release the above images and take full responsibility for all images released to me, my designee or other facility.

Patient Signature____________________ Designee Signature____________________

Print name____________________ Print Name____________________

Date____________________ Date____________________

For Office Use Only

Two Forms of ID	Patient	Designee
Driver's License # or Photo ID:____________________	❑	❑
Other form of ID (don't list #) :____________________	❑	❑