MEDICAL RECORDS REQUEST

Patient First & Last Name: ____

Patient Date of Birth: __________ / __________ / ______________

I request and authorize ______________________________ to release health care information of the patient named above to **North Star Radiology** for the purpose of: (check all that apply)

- ☐ **Prior imaging of**: ____
  ☐ Disk ☐ Faxed Report ☐ Both
- ☐ **Chart notes on**: ____
- ☐ **Blood work within the last two months**: ______________________________
- ☐ **Surgery notes on**: ____
- ☐ **Other**: ____

Patient Signature: ______________________________ **Date**: ______ / ______ /________

CONSENT OF GUARDIAN OR AUTHORIZED PERSON

Signature of Parent/Guardian: ____

Date: ______ /______ /________ **Relationship to Patient**: ______________________________

DISCLAIMER: If a minor consented to health care without parental consent for his/her own treatments, then the minor must consent or release of health care information. North Star Radiology is hereby released from all legal responsibility or liability for the release of the above-mentioned information. Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information. You are entitled to a copy of the authorization. You may revoke this authorization by a written request.

NORTH STAR RADIOLOGY
2310 Peger Road, Ste 102, Fairbanks, AK 99709
Phone: 907.459.6555 · Fax: 907.459.6566
northstarradiology.com