



HEALTH INFORMATION SERVICES

Release of Information Department
89 South Patterson Avenue
Santa Barbara, CA 93111

Phone: (805) 692-6435
Fax: (805) 692-4699

AUTHORIZATION TO RELEASE
RADIOLOGIC RECORDS

Patient Name:
Date of Birth:
Phone Number:

A. Indicate record(s) requested by checking corresponding line below:

- CT scan Mammogram
PET X-ray
PET/CT MRI
Other

Specify:

- B. Indicate preferred medium or format for delivery:
Film- \$15 per film
CD- \$7.00 (Rush-\$15.00)
Report

Ready within 48-72 hours

C. Delivery address (recipient):

Person/Organization authorized to receive radiology records as indicated here:
Complete address, including zip code:
Check here if this is a pick-up: Date and time for pick-up:

D. Confirmation of all the above information:

Patient or patient representative signature: Date:

If patient representative, indicate relationship to patient: