MEDICAL RECORD RELEASE FORM
Request to provide medical data for treatment

INSTRUCTIONS: Complete this form in its entirety and forward or fax to:

☐ RAA Imaging ☐ High Resolution ☐ Albuquerque Imaging Center

4411 The 25 Way NE, Suite 150 Albuquerque, NM 87109
Phone: (505) 332-5811 Fax: (505) 332-5887

Patient Last Name (print)	**Patient First Name (print)**	**Date of Birth**
		/ /

Describe Records Needed (Reports, Films or CD):
Name of Medical Practice Requesting Records:
Name of Physician Requesting Records:
Date Records Needed:

Films will be picked up by other person Yes_____ No_____

If yes, full name of person to pick up _____
(must present photo I.D.)

Signature at the time of release _____ Date _____

Please send the record listed above to:

Name: _____ Phone #: _____

Address: _____ Fax #: _____

The following must be completed by patient

I certify that the requested records will be used solely for treatment of the patient and shall expire no later than: ___/___/___ and may not be valid for greater than one year from the date of signature.

_____ _____
Signature of patient **Date**

_____
Printed Name

Complete by office staff only

Complete by _____ Date____/____/____ Time_____

Original request made by: Telephone _____ Fax _____ Written _____

Name of original requestor: _____