

## AUTHORIZATION FOR USE AND DISCLOSURE OF DIAGNOSTIC MEDICAL IMAGES AND REPORTS

Completion of this document authorizes the disclosure and/or use of identifiable health information, as set forth below, consistent with California and federal law concerning the privacy of such information. Failure to provide all information requested, including the pre-payment processing fee might invalidate or delay the processing of this Authorization. Patient will be contacted when the request has been processed.

### AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND MEDICAL IMAGES

This authorization for use or disclosure of medical images is required by state and federal law. MR # \_\_\_\_\_

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Last First MI

Daytime Telephone Number \_\_\_\_\_ Social Security No: \_\_\_\_\_

### I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF THE ABOVE HEALTH INFORMATION AND RELEASE OF MEDICAL IMAGES FOR MYSELF OR FOR A MINOR FOR WHICH I AM THE GUARDIAN

**Organization releasing information.** Choose the location based on the location of your doctor. If your doctor is in:

**Cupertino, Los Gatos, Mountain View,  
Santa Clara and Sunnyvale**

**Dublin, Fremont, Los Altos, Menlo Park,  
Palo Alto, Portola Valley and Redwood City**

**Aptos, Capitola, Santa Cruz,  
Scotts Valley, Soquel and Watsonville**

Mail or FAX Form to:

**Diagnostic Imaging Request**

701 E. El Camino Real  
Mountain View, CA 94040  
Phone: 650-934-7757  
Fax: 650-934-7790

**Diagnostic Imaging Request**

795 El Camino Real  
Palo Alto, CA 94301  
Phone: 650-853-4876  
Fax: 650-853-609

**Diagnostic Imaging Request**

2025 Soquel Avenue  
Santa Cruz, CA 95062  
Phone: 831-458-5521  
Fax: 831-423-0716

I authorize \_\_\_\_\_ to pick up the requested items below on my behalf.

Patient's Guardian - Printed Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Patient/Patient's Guardian - Signature \_\_\_\_\_ Date \_\_\_\_\_

### RELEASE THE ABOVE HEALTH INFORMATION AND MEDICAL IMAGES TO

(NAME OF PERSON OR ORGANIZATION RECEIVING INFORMATION)

STREET ADDRESS

CITY

STATE

ZIP CODE

**THIS AUTHORIZATION APPLIES TO THE SELECTED IMAGE CATEGORIES.** Prior to requesting medical images, please verify the media type with your physician. Indicating incorrect media types may incur additional fees.

All requests will be processed within 1–2 business days. Urgent/stat requests will be processed based on volume and availability  
*Cds are not protected and are the patient's responsibility to safeguard. Please indicate specific study types and the dates.*

CDs are \$10 each and FILMs are \$10.00 per sheet

Exam Type	Films ONLY- No Charge	Exam Date(s)
<input type="checkbox"/> Mammograms	<input type="checkbox"/> CD <input type="checkbox"/> FILM	_____
<input type="checkbox"/> X-rays	<input type="checkbox"/> CD <input type="checkbox"/> FILM	_____
<input type="checkbox"/> MRI	<input type="checkbox"/> CD <input type="checkbox"/> FILM	_____
<input type="checkbox"/> CT	<input type="checkbox"/> CD <input type="checkbox"/> FILM	_____
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> CD <input type="checkbox"/> FILM	_____
<input type="checkbox"/> Nuclear Medicine Scans	<input type="checkbox"/> CD <input type="checkbox"/> FILM	_____

Requested Items will be:     Mailed     Picked Up

\*\* Requested items that are not picked up within 60 days of request will require a new submission. \*\*

**Staff use only:**     Personal use     Continued Care     Paid