AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Previous Name (if different): _____

Date of Birth: _____ Medical Records # (if known): _____

Address: _____ Phone Number: _____

_____

_____

Records requested	Exam(s) Needed	Date of Exam
◯ Reports	_____	_____
◯ Images	_____	_____
◯ Billing	_____	_____
◯ All		

Notes: _____

◯ I hereby authorize The McGinley Clinic/ Elite Imaging Center to release the requested medical records to the following facility/physician:

_____

_____

_____

◯ I hereby authorize you to release the requested medical records to The McGinley Clinic / Elite Imaging Center.

The McGinley Clinic / Elite Imaging Center
234 East First Street
Casper, WY 82601
(Phone) 307-315-6304
(Fax) 833-992-2034

Patient or Legally Authorized Representative Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

***We use AMBRA Health Imaging Management and can send imaging electronically to most locations.

*** There is a $25 fee to have your imaging printed and mailed.