Medical Records
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Houston, TX 77054-2900
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Medicalrecords@priviagcimaging.com

AUTHORIZATION TO RELEASE MEDICAL RECORD

Patient Name:_____ Date of Birth:_____

Address:_____

Phone Number: _____

Mail my radiology images and reports to:

_____
Name of Facility

_____
Phone Number

_____
Street Address

_____
City, State, Zip Code

TYPE OF RELEASE: [ ] Pick up in person [ ] Mail to resident address [ ] Send to above facility

TYPE OF EXAM: [ ] Mammogram [ ] Breast Ultrasound [ ] Pelvic Ultrasound

[ ] OB Ultrasound [ ] Bone Density [ ] All other ultrasounds

EXPIRATION DATE: This authorization will expire on: (date or event) _____. (if no date or event is stated, expiration is one year from signature date)

_____ _____
Patient Signature Date

Revised 04/27/2023