CENTER FOR DIAGNOSTIC IMAGING

OUTSIDE RECORDS RELEASE

I hereby authorize:____,

(Hospital/Clinic, City, State)

To release records to:

St. Louis Park CDI
5775 Wayzata Boulevard, Suite 190
St. Louis Park, MN 55416

Phone: 952-541-1840 Fax: 952-513-6881

Regarding the Following Patient:

Patient Name_______________________________________ Phone #________________________

Other Names_______________________________________ Date of Birth______________________

Address____ SSN#__________________________

MRN #____

Records to be Released:

☐ Pre & Post Operative ☐ MRI ☐ CT ☐ PET/CT
☐ General Radiology ☐ Ultrasound ☐ Mammography
☐ Entire Record ☐ Other_________________________________

Purpose of Release:

☐ Continuing Care ☐ Insurance ☐ Litigation ☐ Personal Use
☐ Other_____________________________

This authorization expires on the following date, event or condition:___________
If I do not specify any expiration date, event or condition, this authorization will expire in one year.

Statement of Authorization:
Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to CDI (Medical Records). A photocopy/fax of this authorization will be treated in the same manner as the original.

I do not authorize further release to any third party. I understand that once information is released as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

____ ______________________________
Signature of Patient/Legally Authorized Representative Date

____ ______________________________
Relationship to Patient Reason Patient Unable to Sign

____ ______________________________
Signature of Witness (Verbal Authorization Only) Signature of Witness (Verbal Authorization Only)

OFFICE USE ONLY: Patient Account Number:______________________________