Patient Name (Please print)_______________________

Patient ID (Please print)_________________________

Date__________________________________

CONSENT TO RELEASE MEDICAL FILMS / STUDIES / AND RECORDS

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I, ____*(print name),* hereby authorize the release of the following medical information for diagnostic evaluation and comparison to:

- ☐ NM___________________
- ☐ X-ray _________________
- ☐ Ultrasound _____________
- ☐ Mammogram **_________
- ☐ MRI___________________
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- ☐ Report (s) ***

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I further authorize the acceptance of a copy, facsimile or other electronic image of this form bearing my signature to be used for purposes of releasing the information as instructed above. I acknowledge that Compass is not responsible for lost films or films damaged during shipment to or from the facility. This authorization expires 90 days form the date noted above.

______________________________	______________________________
Patient Signature	Patient Name (Please print)
______________________________	______________________________
Social Security #	Date of Birth
______________________________	______________________________
Address	City, State, Zip
______________________________	______________________________
Witness Signature	Witness (Please print)