Imaging for Women, LLC
630 NW Englewood Road
Kansas City, MO 64118
Phone: (816) 453-2700

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Last Name:	Patient First Name and Middle Name/Initial:		Date of Birth:
Street Address:	City, State, and Zip Code:		
Home Phone:	Mobile Phone:	Email Address:	

Exam(s) Requested:
Date(s) of Service:

Please mark the appropriate box below for your request:

- ☐ **DVD (DICOM) Images Only**
- ☐ **Reports Only**
- ☐ **Both DVD (Images) and Reports**

If a provider is requesting the images and/or reports, please complete the below fields.

Provider First Name:	Provider Last Name:
Provider Phone Number:	Provider Fax Number:
Address:	Suite:
City, State, and Zip Code:	

Who will pick up the images? To assure your privacy, all individuals picking up DVDs/Reports will be required to provide a photo ID.

- ☐ **Patient**
- ☐ **Other** - Name: ______________________________
  Relationship: _________________________

Comments:

Disclaimer

By signing this form, I authorize Imaging for Women to release confidential health information about me by releasing a copy of my medical records. I understand that I may revoke or terminate this authorization by submitting a request in writing to: Imaging for Women, LLC, 630 NW Englewood Road, Kansas City, MO 64118.

X ____ ___________________________

Patient or Legal Guardian Signature *Date*