

## Release of Medical Information

For Treatment, Payment, or Healthcare Operations  
( Film Release) Form #108

**ALL of the information must be completed in order to process the request.**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone Number: Day \_\_\_\_\_ Evening \_\_\_\_\_

Describe in detail the pertinent information to be used or disclosed (i.e. service date, exam name):

Imaging Films (CT, MR, and US imaging will be provided on CD unless specified otherwise): \_\_\_\_\_

Imaging Reports Re: \_\_\_\_\_

Other (describe in detail): \_\_\_\_\_

Organization providing the information:

**Suburban Imaging - Burnsville**  
**14000 Nicollet Avenue, Suite 204**  
**Burnsville, MN 55337**

Phone Request

I am requesting these films be **permanently transferred**  
to the persons/organization receiving the information.  
(Copy legal document and scan into patient record.)

I am requesting these films be **loaned** for comparison  
and returned to the originating facility.

Persons/organization receiving the information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Person picking up films

ID verified (ie: driver's license)

Films mailed: verify patient address and date of birth

### Important Things to Note:

- This authorization will expire on \_\_\_\_\_, (max. 1 year from date of completion)  
unless it is revoked in writing by the undersigned and sent to:

**Suburban Radiologic Consultants**  
**Pat Kinsley, Compliance Manager**  
**4801 W. 81st Street, Suite 108**  
**Bloomington, MN 55437**

- Minor patients (under 18 years of age) authorization must be signed by a parent or legal guardian.
- Please be aware that once this information is disclosed to the individual/organization listed above, it may not be re-disclosed by them to individuals or organizations MN statute 144.335.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Legal Authority \_\_\_\_\_ Copy Legal Document \_\_\_\_\_

**Upon signing the patient will be given a copy of this request.**

#### OFFICE USE ONLY

Date Received \_\_\_\_\_ Request Received By \_\_\_\_\_ Copy Given to Patient (Date) \_\_\_\_\_

Request Finalized By \_\_\_\_\_ Requested Finalized on Date \_\_\_\_\_ Doc Scanned (Date) \_\_\_\_\_