



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 - Centennial Lakes
7373 France Ave S., Suites 100 & 204
Edina, MN 55435

Phone Request

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) _____