SDMI

MEDICAL RECORDS RELEASE FORM

IMAGES REQUESTED TO BE RELEASED FROM

Institution Name_____Phone_____Fax_____

Address:_____

CD/FILMS NEEDED

Patient Name_____Patient Date of Birth_____

Previous or Other Name Known By_____

Present Address_____

Present Home Phone_____Present Work Phone_____

Previous Type of Exam(s) Requested_____

The above named patient has informed SDMI that he/she has previously had radiological examination(s) completed at your institution. Please send the CDs/Film(s) and a copy of the report(s) to:

☐ **NORTHWEST**
2767 N Tenaya Way
Las Vegas, NV 89128
Attn: File Room

☐ **MARYLAND PARKWAY**
2950 S Maryland Pkwy
Las Vegas, NV 89109
Attn: File Room

SDMI will return your films promptly upon completion of comparison reading.

I hereby authorize release of medical information as indicated above

Patient Signature: _____ Date: _____