JOHNSON COUNTY IMAGING

Email requests to: medicalrecords@jocoimg.com

AUTHORIZATION FOR RELEASE OF MEDICAL IMAGES, REPORTS AND MEDICAL RECORDS

Patient Name: _____

Previous Name: (If Different):_____ Medical Record #:_____

Date of Birth: _____ Street Address: _____

City: _____ State: _____ Zip: _____

Images/Medical Record Information Requested: _____

_____

☐ I hereby authorize you to release to Johnson County Imaging, or its representatives, the following Mammography Images and/or records (listed above)

Please send to the following address:
Johnson County Imaging
11717 W. 112th St. Suite 500
Overland Park, Kansas 66210

☐ I hereby request PERMANENT TRANSFER of my mammograms to Johnson County Imaging per MQSA regulation 900.12©(4)

☐ I hereby authorize Johnson County Imaging to release the listed medical images and/or records to the facility/physicians(s) listed:

_____
_____
_____

Patient Name: _____ Date: _____

Patient or Legally Authorized Representative Signature: _____

If signed by anyone other than patient, Relationship to Patient: _____