BLUE STAR IMAGING
At The Star

PATIENT NAME: _____

PHONE NUMBER: _____

PATIENT DATE OF BIRTH: _____

DATE(S) OF TREATMENT: _____

I, authorize Blue Star Imaging to use or disclose the information specified below from the medical record of the above-named patient.

PATIENT INFORMATION IS NEEDED FOR | PLEASE SELECT ONE OPTION

☐ CONTINUING MEDICAL CARE ☐ PERSONAL USE ☐ LEGAL PURPOSES

INFORMATION TO BE RELEASED OR ACCESSED:

☐ RADIOLOGY IMAGES ☐ RADIOLOGY REPORTS ☐ OTHER _____

METHOD OF DELIVERY:

☐ PICK UP

☐ EMAIL ADDRESS _____

☐ MAIL TO ADDRESS LISTED

_____ _____

(NAME) PHONE NUMBER

_____

ADDRESS (STREET, STATE, ZIP CODE)

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_____ _____

SIGNATURE | PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE DATE

_____

PRINTED NAME OF PATIENT OR LEGALLY AUTHORIZED REPRESENTATIVE

_____

RELATIONSHIP TO PATIENT