clearreview
1521 Second Avenue #606
Seattle, Washington 98101
877.3433.243
www.clear-review.com

For office use

Patient Authorization for release of information

Patient Name:_____ DOB:_____

I authorize _____ to release a copy of my
(Name of person or facility which has information)
protected health information, specifically ☐all digital ☐selected (see below) radiology exams and associated reports, to:

Clear Review, Inc.
1521 2nd Avenue #606
Seattle, Washington 98101

Limitations to release of records:

☐Release only exams performed between _____ and _____ .
(date) *(date)*

☐Release only exams of the following types:

☐Plain films (regular X-rays)
☐Computed Tomography (CT)
☐Magnetic Resonance Imaging (MRI)
☐Ultrasound
☐Nuclear Medicine
☐Positron Emission Tomography (PET)
☐Mammography (Digital only)

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary.
- I can cancel this authorization at any time; provided, however, I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.

_____ / / _____
Signature of Patient or Legally Responsible Party Today's Date

_____ ( ) - _____
Relationship to Patient, if not signed by patient Phone Number

