KONA
COMMUNITY HOSPITAL
Care You Can Count On

CONSENT TO RELEASE COPIES OF IMAGES AND/OR REPORTS

I hereby authorize Kona Community Radiology Department to release information regarding:

Patient Name:_____ D.O.B._____

Address: _____ Phone Number: _____

I understand the information will be released to:

Dr.: _____

PATIENT SIGNATURE: _____ Date: _____

Print Name: _____

RELATION TO PATIENT: _____

WITNESS: _____

MEDICAL RECORD NUMBER: _____

IMAGING STUDY OF: _____

DATE OF EXAM(S): _____

□ Report Requested (check if yes)

CDs ARE COPIES AND DO NOT HAVE TO BE RETURNED.

Identity of authorized signer verified by: □ State I.D. □ Driver's License □ Other

RADIOLOGY STAFF SIGNATURE: _____

The Imaging Center
Kona Community Hospital
79-1019 Haukapila Street
Kealakekua, Hawai'i 96750
(808) 322-4423
(808) 322-4576 Fax

*** PLEASE SCAN THIS COMPLETED DOCUMENT INTO THE PATIENT'S FILE ***