KONA
COMMUNITY HOSPITAL

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)**

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Identity of authorized signer verified by: ☐ **State I.D.** ☐ **Drivers License** ☐ **Other**

RADIOLOGY STAFF SIGNATURE: _____

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• PLEASE SCAN THIS COMPLETED DOCUMENT INTO THE PATIENTS FILE •