



Mountaineer Imaging
60 RHL Blvd.
South Charleston, West Virginia 25309
304-720-9729 (Phone) 304-720-9730 (Fax)

RECORDS RELEASE AUTHORIZATION

I hereby authorize release of my medical records to Mountaineer Imaging.

NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

SSN: _____

DATE SIGNED: _____

SIGNATURE: _____

These records will not be disclosed to any other entity or third party without the written consent/permission of the patient.

(This form is valid for one year from the date of signing.)