



**Oregon Health & Science University
Hospitals and Clinics
OHSU Image Library**
3181 SW Sam Jackson Park Rd,
Mail Code: UHS 5 Portland, OR 97239-3098
(503) 494-8631, Fax (503) 494-5020
Business Hours: Monday-Friday, 6:30 AM-6:00 PM

ACCOUNT NO. _____
MED. REC. NO. _____
NAME _____
BIRTHDATE _____

OHSU Image Library – Film/CD Request Authorization Form

Release Authorization:

This authorization must be written, dated, and signed by the patient or person authorized by law to give this authorization. I hereby authorize the Diagnostic Imaging Department/Image Library of Oregon Health & Science University to provide diagnostic images and/or films to the Requestor (listed below). The information will be used on my behalf for the following purpose(s):

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request

Patient or Authorized Person First/Last Name (PRINT)

Signature

Date

TODAYS DATE/TIME

DATE/TIME (REQUIRED)

IMPORTANT: Please set a due date and time based on your needs, such as patient appointment, surgery date/time, etc.

Date of Exam	Description of Exam (please be SPECIFIC, e.g. MRI L-spine instead of just 'MRI')	CD	Film	Quantity	Anonymize

Requester Information (all fields are required):

Reports Faxed

Fax# _____

Last/First Name:	Facility Name:	Contact Phone Number:
Mailing or Delivery Street Address:	City, State & Zip	
		Call when ready # _____ Text page when ready # _____

Shipping Instructions:

Send: Pick-up Campus Mail Mail Courier **TO:** Patient Clinic Student Other

Special Instructions:

Received By:

Name: _____ Signature: _____ Date: _____



MR1470