Capital Imaging

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print

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Patient Name Other Last Names

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Date of birth Phone Number Email Address

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Street Address City, State, Zip code

I hereby authorize **Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103**, on behalf of Capital Imaging, 4927 Auburn Ave Ste T-25, Bethesda, MD 20814, to release a copy of my reports.

Please select one of the following delivery options:

☐ Secure HIPAA approved electronic transfer to patient; not to the Physician's office.
List your email address here ____

☐ Pick up disc, in person, at Morgan Records, 159 Frontage Road, Manchester, NH 03103. Available office hours are Monday – Thursday 8am-4pm. A 48 hour notice for pick up is required.

☐ Disc mailed to home or physician/facility. There will be a $10 shipping charge prior to mailing. We mail USPS Certified Return Receipt. List address here:

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I, ____, am the patient or legal guardian who has authorization to release the above records. Any facsimile, copy, or photocopy of this release will be valid for 90 days and shall authorize you to forward my ultrasound reports. Only records from this facility can be legally released. Any records from other physicians or facilities must be obtained from them directly.

Please note; a $25 records management fee is requested to process & deliver your medical records.

Payment Options:

CREDIT CARD – please circle this option, once I find your records I will call to process payment over the phone.

CHECK - please mail your completed authorization form with an attached check or money order made payable to Morgan Records Management LLC, to 159 Frontage Rd, Manchester, NH 03103.

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Patient or Legal Guardian Signature Date

Your completed authorization form may be faxed to 603-509-3987, emailed to Marie@MorganRecordsManagement.com, or mailed to Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103.