



Email requests to: [medicalrecords@jocoimg.com](mailto:medicalrecords@jocoimg.com)

## AUTHORIZATION FOR RELEASE OF MEDICAL IMAGES, REPORTS AND MEDICAL RECORDS

Patient Name: \_\_\_\_\_  
Previous Name: (If Different): \_\_\_\_\_ Medical Record #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Images/Medical Record Information Requested: \_\_\_\_\_  
\_\_\_\_\_

I hereby authorize you to release to Johnson County Imaging, or its representatives, the following Mammography Images and/or records (listed above) Please send to the following address:  
Johnson County Imaging  
12000 W. 110th St. Suite 500  
Overland Park, Kansas 66210

I hereby request PERMANENT TRANSFER of my mammograms to Johnson County Imaging per MQSA regulation 900.12©(4)

I hereby authorize Johnson County Imaging to release the listed medical images and/or records to the facility/physicians(s) listed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Legally Authorized Representative Signature: \_\_\_\_\_

If signed by anyone other than patient, Relationship to Patient: \_\_\_\_\_

12000 W. 110th St. Suite 500 Overland Park Kansas 66210 913.469.8998 Phone 913.469.5695 Fax  
CT | DEXA | 3D MAMMOGRAPHY | FLUORO | MRI | NUCLEAR MEDICINE | ULTRASOUND | XRAY  
[johnsoncountyimaging.com](http://johnsoncountyimaging.com)

ACR Accredited Facility: CT Mammography Nuclear Medicine MRI