

BrightWay Imaging
A Smarter Healthcare Solution

CONSENT TO RELEASE HEALTH INFORMATION

I, _____, give BrightWay Imaging my permission to release my medical report(s) for this date of service to the person(s) listed below.

If the names on this list changes at any time, please contact our office as soon as possible with the changes.

1. _____
2. _____
3. _____
4. _____

Patient Name (printed)

Date of Birth

Patient Signature

Today's Date