

PARK CITY IMAGING
1850 SIDEWINDER DRIVE, SUITE 410
PARK CITY, UT 84060
PHONE: 435-615-0250
FAX: 435-615-0252

Fecha: _____ Account# _____

LIBERACION GENERAL DE REGISTROS

Nombre del Paciente: _____ Fecha de Nacimiento: _____
Escriba por favor

Tipo de Imagen Solicitada: _____

Fecha(s) del Servicio: _____

Con la presente autorizo la liberacion de mis registros de _____
Nombre del Centro Medico
sean otorgadas a Park City Imaging. Favor de mandar los registros solicitados a la direccion otorgada anteriormente.

Firma del Paciente: _____
Fecha: _____

Firma del Empleado: _____

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