

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: \_\_\_\_\_

CONFIDENTIALITY NOTE: The information in this facsimile message may be legally privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any use, dissemination, distribution, or copying of this information is strictly prohibited and may result in violation of federal or state law. If you have received this telecopy in error, please notify us immediately by calling the telephone number above. Please destroy the original message. Thank you.