AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby request the release of my medical records to be sent to:

☐ **Bright Light Medical Imaging**
31 S Arlington Heights Rd
Elk Grove Village, IL 60007
P: 847-439-2315 F: 847-439-3935

☐ **Bright Light Medical Imaging**
7456 S State Rd, Suite 100
Bedford Park, IL 60638
P: 708-930-1420 F: 708-924-1214

☐ **Bright Light Medical Imaging**
8319 W North Ave
Melrose Park, IL 60160
P: 708-450-9800 F: 708-450-9975

☐ **Bright Light Medical Imaging**
7372 Kingery Hwy
Darien, IL 60561
P: 630-455-5552 F: 630-455-1090

Type of Exam :

☐ Mammogram (including breast ultrasound)

☐ MRI ☐ CT ☐ Ultrasound ☐ X-ray ☐ All exams

☐Other ____

Date of Exam :

☐ Any dates Specific date (s)______________________________

Requesting from : (Which medical facility should send your records?)

Facility Name____

Address____

City/State____________________________________ Zip code___________

Patient Information :

Patient Name : (Print) ____

Patient DOB : __________________________________

Patient Phone Number : __________________________

Patient Signature : ____

Date:___________________