SonoNet® *a mobile ultrasound company* www.sononet.us

Request for Release of Confidential Information

To: _____ At: _____

Name (Practice Contact) Practice Name – (SonoNet Business Associate (HIPAA))

Fax: _____

Patient Name: _____

Date study was performed:

Type of study performed: _____

Please forward the information to:

_____

Person / organization receiving the information

_____

Address, City, State, Zip

_____

Telephone

Specific description of requested information:

☐ Actual Copy of Study (CD format) ☐ Report (paper)

☐ Both ☐ Other _____

FOR SONONET INTERNAL USE ONLY
Received
Completed: Initial & Date

Signature: _____

Authorized Business Associate Physician / Staff

RETURN REQUEST BY FAX TO (816) 581-2090

(Information will be sent within 48 business hours of request.)

phone **(816) 569-2200** **901 W 43rd St, Kansas City, MO 64111** *fax* **(816) 581-2090**