

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 _____

Signature: _____
Authorized Business Associate Physician / Staff

FOR SONONET INTERNAL USE ONLY
Received
Completed: Initial & Date

RETURN REQUEST BY FAX TO (816) 581-2090

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

CONFIDENTIALITY NOTICE: This communication may contain Protected Health Information, as defined by the Health Insurance Portability and Accountability Act (HIPAA), that is privileged, confidential, or exempt from disclosure by federal or state laws. The information contained in this email message is intended only for the use of the individual or entity named above. If you are not the intended recipient, please note that any dissemination, distribution, or copying of this communication is strictly prohibited. Anyone who receives this message in error should notify the sender at SonoNet at (913) 888-8866 or email and return the document in its original form. Thank you.