TRA Medical Imaging

Patient Film and Report Request

Patient Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Date of Birth _____ Last Four SSN # _____

Exam #1 _____ Exam Date _____

Exam #2 _____ Exam Date _____

Exam #3 _____ Exam Date _____

I hereby authorize the release of my records to the following:

❑ Mail to the below: ❑ Fax to the below:

Business or Health Care Facility _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Authorizing Signature _____ Date _____

Relationship to Patient _____

Send this form to Medical Records Department: Fax (253) 383 0730, or PO Box 1535, Tacoma WA 98401

***Please note:** Email is not a secure way to send personal information. To protect your privacy, we recommend you mail or fax this form.*

Staff Member _____

Date _____ Patient MRN _____