RELIANT MEDICAL GROUP RADIOLOGY

Authorization to Disclose Radiology Medical Record Information

Please send completed form to:
5 Neponset Street
Worcester, MA 01606-2714
Ph: (508) 853-2716 • Fax: (508) 856-9025

Completed by (For office use only): MRN: _____

Form Completed By: _____ Dept: _____ Date: _____

☐ Originals ☐ Duplicates Appt. Date: _____

Patient Information

Patient's Name: _____

Patient's Address: _____ D.O.B: _____

City: _____ State: _____ Zip: _____ Phone #: ( )_____

Release Information

I hereby authorize Reliant Medical Group Radiology to:

☐ **Mail my radiology images/reports to:** ☐ **Obtain my radiology images/reports from:** ☐ **Patient pickup at:** _____

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of request: ☐ Personal ☐ Continuing care (referral/2nd opinion) ☐ Transfer of care (new physician)
☐ Legal ☐ Insurance ☐ Other: _____

Information to be Released

☐ Images on disk ☐ Hard copy films ☐ Reports

1. Type of exam: _____ Dates(s) of exam(s): _____

2. Type of exam: _____ Dates(s) of exam(s): _____

3. Type of exam: _____ Dates(s) of exam(s): _____

Record Return, if applicable

I understand that the original films are a permanent part of my medical file. If this request requires the original films to be provided to me, I also understand that it is my responsibility to return them. They can be dropped off at any Reliant Medical Group location or mailed to:

☐ Reliant Medical Group Radiology, Attn: Imaging Library, 5 Neponset Street, Worcester, MA 01606

☐ Reliant Medical Group Radiology, Attn: Imaging Library, 225 New Lancaster Road, Leominster, MA 01453

I understand that I have a right to revoke this authorization at any time by providing a written statement to the Imaging Library at Precision Medical Imaging. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand, unless otherwise revoked or specified, this authorization is valid for 365 days.

Please specify an expiration date if other than 365 days:_____.

I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to assure treatment. I understand that my health record may contain general information related to my mental health, drug/alcohol abuse, or other information that I may consider sensitive. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Signatures

Patient/Legal Representative Signature: _____ Date: _____

Print Name of Patient/Legal Representative: _____

If signed by Legal Representative, Relationship to Patient: _____

*Copy of signed supporting legal document showing your status as authorized representative with access to member's/patient's records must accompany request.

This authorization must be completed in its entirety or it will not be processed.

Request Completed By: _____ Date: _____