



Authorization to Disclose Radiology Medical Record Information

Please send completed form to:
5 Neponset Street
Worcester, MA 01606
Ph: (508) 853-2716 • Fax: (508) 425-6053

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 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): _____

I understand that I have a right to revoke this authorization at any time by providing a written statement to the Imaging Library at 5 Neponset Street. 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: _____

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

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