



### Medical Records Request

I, \_\_\_\_\_, hereby authorize Radia to disclose the health information of:

\_\_\_\_\_

\_\_\_\_\_

**Name of Patient (please print)**                      **Medical Record Number**                      **Date of Birth**

**Information to be sent to:**     Self    OR

**Name of recipient:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**City, State, Zip:** \_\_\_\_\_ **Phone:** (\_\_\_\_) \_\_\_\_\_

**Health Information to be Disclosed:**

Radiology Report(s)                       Radiology Image (s)  
 Other (please specify): \_\_\_\_\_

**Exam Type(s):** \_\_\_\_\_  
**Date(s) of Service:** \_\_\_\_\_

**Patient Authorization:**

I understand that my records may contain information regarding diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment unless specifically excluded.

Please check only if you do NOT want this information released:

Drug/Alcohol abuse/treatment & diagnosis                       Sexually Transmitted Disease  
 HIV/AIDS diagnosis/treatment Testing                       Mental health or Psychiatric diagnosis/treatment

**Patient Rights:**

- Authorizing the disclosure of health information is voluntary. I do not need to sign this for treatment. I may still obtain a copy of my records should I not desire to complete/sign this form.
- I may revoke this authorization at any time in writing to the facility releasing information. I understand that once information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release and distribution that may not be protected by confidentiality laws.
- I can request a copy of this authorization from the representative processing the authorization.
- This authorization will expire 90 days from the date signed below unless another date or event is entered here: \_\_\_\_\_ . Exception: If information is released to an employer or financial institution, this authorization is valid for 90 days from the date signed.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If other than Patient, indicate relationship to Patient: \_\_\_\_\_

(Guardian, Authorized Representative: Please provide documentation to confirm authority to sign on behalf of patient)

CD/Films Created By			
Correct Images/Records Verified by			
Delivered to Patient/ID Verified by		Date	