SWEDISH RADIA IMAGING CENTER AT EDMONDS

Swedish Radia Imaging Center 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)**

☐ **Images on CD**

Or

☐ **Images to Ambra portal/notify by email (email address required)**

Email: _____

☐ 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**
☐ **HIV/AIDS diagnosis/treatment Testing**
☐ **Sexually Transmitted Disease**
☐ **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 Created By:	Correct Images/Records Verified By:
Delivered to Patient/ID Verified By:	Date:

Image upload to Ambra By:	Date: