SouthSound RADIOLOGY

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Authorization to Release Medical Information

Please complete the following information. Please print clearly.

Patient Name**: _____DOB**: _____

Please have my information ready for *(please circle)*: **Pick up** **E-Mail** (report only) **Send to:**

Name of person/Organization: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

***Important Notice* : Personal information released via e-mail is encrypted**. I authorize my information to be sent **unencrypted** (initial here) _____.

Email: _____

Phone_____ **Fax #**_____

Information to be disclosed *(please circle)*:

Radiology Report Only **Both Images and Report**

Exam Type *(please circle)*: **MRI CT ULTRASOUND MAMMOGRAM X-RAY DEXA**

Dates(s) of Service: _____ **-** _____ **Notes:** _____
_____

Patient Rights:

- 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.

***Patient Signature**: _____**Date**: _____