

LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C.

AUTHORIZATION TO DISCLOSE/RELEASE MEDICAL RECORDS

PLEASE PRINT ALL INFORMATION

Patient Name: (First) _____ (Last) _____

Date of Birth: mm/dd/yyyy / / SSN#:

Phone #: _____

(Please supply phone # where you can be reached between 9am -5pm)

Exam: (Please check the exam(s) to which you are requesting reports/films)

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> CT | <input type="checkbox"/> MR | <input type="checkbox"/> PET |
| <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> X-ray | <input type="checkbox"/> Bone Densitometry |
| <input type="checkbox"/> Sonogram/Ultrasound | <input type="checkbox"/> Mammogram | <input type="checkbox"/> Fluoroscopy |
| <input type="checkbox"/> Other: | | |

Please provide a description of the exam you are requesting reports/films on (eg. CT Chest or MRI Head):

Date of Exam: mm/dd/yyyy / /

Are you requesting REPORTS FILMS

• If you are requesting REPORTS, please indicate how would like to receive them:

- Fax Mail Collect in person Email

• If you are requesting FILMS, please indicate how would like to receive them:

- Mail Collect in person CD - send by mail
- collect in person

• Who would you like to receive your reports/films:

- You Referring Physician Another Physician Other

• If you would like your reports/films to be sent to you, please fill out the below information:

Patient Mailing Address:

Phone #: _____ Fax#: _____ Email Address: _____

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- If you would like your reports/films to be sent to your referring physician, please fill out the below information:

Referring Physician Name:

Mailing Address:

Phone #:

Fax#:

- If you would like your reports/films to be sent to another physician or (other), please fill out the below information:

Name:

Mailing Address:

Phone #:

Fax#:

I authorize the release of my medical records as indicated above. I understand the release of these films/reports will no longer preserve the confidentiality of my records and the information contained therein. I hereby release LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C., and all of their personnel, both technical and administrative, from any and all liability claims, demands and actions of any kind, which may arise or result from the release of these films/reports. I also agree to pay any fees associated with printing, and mailing the above records.

PATIENTS SIGNATURE:

DATE:

PLEASE NOTE:

- Your request will be ready for collection/mailing approximately 3 days from date of request. Please allow normal time for mailing.
- Our medical records department will contact you (between 9am- 5pm) when your films are printed to advise you of the cost. The cost of printing your case is determined by the number of film sheets used. This number can vary greatly. It is not possible for us to determine this number in advance of printing your case.
- If you would like us to send your films to a different physician other than your referring physician there is a \$10 fee for mailing.
- If your referring physician received an original set of films, reprints are \$12 per sheet.
- If you request a CD of your exam there is a charge of \$30.
- Please refer to www.lenoxhillradiology for more important information regarding your request.

WHEN COMPLETED PLEASE FAX THIS FORM TO (212)-772-0468