AUTHORIZATION TO DISCLOSE HEALTH INFORMATION – MEDICAL RECORDS RELEASE

alexandriaradiology.com

☐ **ALEXANDRIA IMAGING CENTER**
4660 Kenmore Avenue, Suite 525
Alexandria, VA 22304
P 703.751.5055 F 703.370.3889

☐ **WOODBRIDGE IMAGING CENTER**
4001 Prince William Parkway, Suite 302
Woodbridge, VA 22193
P 703. 494.3309 F 703.357.9636

Patient Name: ______________________________ Date of Birth: ____________
LAST FIRST MIDDLE

Address: ______________________________
NUMBER & STREET CITY ZIP

Phone Numbers (Home) ____________________ (Cell) ____________________

If you have medical records at another facility that Association of Alexandria Radiologists, LLC needs to obtain please fill out and sign below:

I hereby authorize the release of my medical records to the facility listed checked above from:

Facility ____________________ Phone ____________ Fax ____________

☐ All imaged data and reports ☐ Specific study(ies) ☐ Permanent release of mammography

If you would like us to release or disclose your results and/or imaging studies and reports to a third party release, another facility, or a family member please fill out and sign below:

I further authorize the disclosure of my radiology medical records from any Association of Alexandria Radiologists, LLC to the following 3rd party individual(s)::

Name: ______________________________ Relationship: ☐ Spouse ☐ Child ☐ Other

Address: ______________________________
NUMBER & STREET CITY ZIP

Phone Numbers (Home) ____________________ (Cell) ____________________

☐ Film/CD (1) Study ____________ Date ______/(2) Study ____________ Date ______

☐ Report (1) Study ____________ Date ______/(2) Study ____________ Date ______

☐ Other ____________________ Date ____________

Released to: ______________________________ Date ____________

This authorization can be revoked at any time with written notification. This authorization expires one year from the date signed.

______________________________ Date:____________
PATIENT (OR GUARDIAN) SIGNATURE

If not signed by the patient, please indicate the relationship: Proof of identity required. ☐ Parent/Guardian
☐ Beneficiary/personal representative of deceased patient ☐ Guardian/conservator of an incompetent patient

Please note, there is no charge for the first CD copy. Additional CD copies are available for a fee of $7.00. Copies of films, if available are $7.00/sheet.

FOR OFFICE USE ONLY Date Request Taken __________ By __________ Date Picked Up __________ By __________
Date Mailed Out __________ By __________ # of Films Signed Out __________ Identification Presented __________