WASHINGTON RADIOLOGY ASSOCIATES, P.C.

RECORDS AUTHORIZATION FORM

Staff initials _____ Date _____ Date and time of pickup _____

Patient name _____ Date of birth _____ Date last seen

Account number _____ Home phone _____ Work phone _____

○ Patient pickup ○ Physician pickup ○ Fax to # _____ ○ Other _____

Delivery type: ☐ USPS ☐ UPS ☐ Other _____

Request *(check all that apply)* ○ Report ○ Film ○ CD Charge for mailing/film/CD: $ _____

I understand it is my responsibility to ensure my studies are received by WRA. (patient initials: _____)

I authorize WRA to: ○ Request from, or ○ Release to: ☐ Complete records, or ☐ Exam(s) _____

Name of Facility/Hospital _____ Department _____

Street address _____ City _____

State _____ Zip _____ Phone _____

Outside studies (CD {preferred}, or film) along with a copy of the report should be sent to the WRA location checked below.

○ 2141 K St NW, #900, Washington, DC 20037, 202-223-9723
○ 3022 Williams Dr, #200, Fairfax, VA 22031, 703-698-8800
○ 21351 Ridgetop Cir, #100, Sterling, VA 20166, 571-434-0140
○ 10215 Fernwood Rd, #103, Bethesda, MD 20817, 301-564-1053
○ 4445 Willard Ave, #200, Chevy Chase, MD 20815, 301-654-4242
○ 12505 Park Potomac Ave, #120, Potomac, MD 20854, 240-223-4700

Prepared by (employee initials) _____ Logged out _____ Date _____

Exam date	Exam type	CD/# films

Exam date	Exam type	CD/# films

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to WRA at 3015 Williams Drive, #200, Fairfax, VA 22031. I understand that a revocation is not effective for prior disclosures of protected health information made with the authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

○ I am receiving original films. I understand that by signing them out from WRA I am responsible for them.

○ I have received a CD/film of the above listed exam(s). ***They should <u>not</u> be returned to WRA.*** I realize there is no charge for the initial set of CD/films or combination of both. The fee for an additional CD is $20; the fee for additional films is $25 per case.

Patient signature (*or person taking records if not the patient*) Relationship Date

Witness Date

○ Person picking up records requests that a copy of their photo ID not be made. Identification has been verified.

Employee #1 Employee #2

AUTHORIZATION EXPIRES 90 DAYS AFTER DATE OF REQUEST

RECAUTH 0712