The Brooklyn Hospital Center
Keeping Brooklyn Healthy

PATIENT AUTHORIZATION FOR RELEASE OF RADIOLOGY RECORDS

SECTION A

Patient's Name: _____ Med. Rec. # (if known): _____

Street/Apt.: _____ Date of Birth: _____

City, State, Zip: _____ Telephone #: _____

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider, the released information may be subject to re-disclosure and may no longer be protected by the federal privacy regulations.

SECTION B

I am requesting the following information:

❑ ALL Radiology/Imaging records from: (Date) _____ to (Date) _____

❑ Radiology/Imaging records confined to the following specific information _____

❑ CD ❑ Imaging via link (email required) ❑ Reports ONLY ❑ (Date) _____ to (Date) _____

SECTION C

Please release information to:

Name: _____

Address: _____

For the purpose of: _____

SECTION D

To be READ AND INITIALED by patient/patient's representative. THIS SECTION MUST BE COMPLETED. This authorization/consent will expire when acted upon or 90 days from the signed date, whichever occurs first.

_____ I understand that I will get a copy of this form after I sign it. I understand that I may revoke this authorization at any time by notifying the hospital in writing, but if I do, the revocation will not have any effect on actions the hospital has already taken in reliance on this authorization.

_____ I understand that if my records contain information concerning drug, alcohol, or mental health treatment such information will be released pursuant to this release form.

_____ I understand that if my records contain confidential HIV related information (indicating that I have had an HIV related test, or have HIV infection, HIV related illness or AIDS, or that could indicate that I have been potentially exposed to HIV), such information will be released pursuant to this consent form. The recipient of this information is prohibited from re-disclosing HIV related information without my authorization unless permitted to do so under federal and state law. I also have the right to request a list of people who may receive or use my HIV related information without authorization.

_____ _____ _____
Signature of Patient or Patient's Representative **Date** **Hospital Personnel/Date**

_____
Printed Name of Patient or Patient's Representative ❑ **Mail** ❑ **In-person** ❑ **Image Share**

_____
Relationship to Patient ❑ **Email** _____