Department of Diagnostic Imaging

Film/CD and Reports Release Authorization

Account Number:______________________

Name: ______________________________________ Medical Record #: _____________________

Address: ____________________________________ Date of Birth: __________________________

____________________________________ Phone: (_____) _______________________

I, _____________________________________Date:________________ am picking up films/CD/reports that were

(Authorization Signature)

taken on the above named patient. My relationship to this patient is ______________________________________.
(self, spouse, parent, etc.)

I will take full responsibility for the care of the films (while on loan from Jordan Hospital) on the above named patient. I understand that these films belong to the Jordan Hospital and are a part of the permanent Hospital Record and that **I am responsible for their return** so that (my) the record can be maintained in a complete fashion. I will personally return these films, or will instruct the physician or facility that I entrust them with for review or comparison to return them immediately upon their completion of review. I understand that these records are subject to **redisclosure** by the recipient and, if so may not be subject to federal or state law protecting confidentiality. I also understand that I may **revoke this authorization** at any time by requesting such of the above-referenced hospital in writing , unless action has already been taken in reliance upon it, or during a contestability period under applicable law. This authorization **expires** after (90) ninety days from the date I signed it unless otherwise specified. **CD's do not need to be returned**.

Information to be disclosed for :_____ Medical Care/ ___Legal / _____ Insurance / ____Personal / __ Other

<u>Type / Quantity Loaned:</u> **Date Loaned:** ________________

Exam________________________________Date of Study) ________________ **Circle 1**- Copies Original Films CD

Exam________________________________Date of Study_________________ **Circle 1-** Copies Original Films CD

Exam________________________________Date of Study_________________ **Circle 1**- Copies Original Films CD

Exam________________________________Date of Study_________________ **Circle 1**- Copies Original Films CD

MRI/CT- Optical disc #-

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<u>Destination of Films/CD:</u>

Physician Name: ____

Facility Name: ____

Address: ____

____

Phone: ____

Radiology Information:

Any Radiology **staff that dispenses** films is responsible for **accuracy and completeness** of the above information. In addition to the above information staff must request to see a photo ID of the person picking up the requested films. __________________________.
(Staff please sign when films are taken). Please provide person signing out films a copy of this document for their records.

________ requestor identification verified by seeing proper identification