Advanced Radiology Health Information Management
3 Enterprise Drive, Shelton, CT 06484
Fax: 203.380.3289 Tel: 203.380.3284 MedicalRecords@AdRad.com

INFORMATION RELEASE AUTHORIZATION - OUTGOING

Patient Name _____ Date of Birth _____

Telephone _____

Email _____

Street Address _____

City _____ State _____ Zip _____

I hereby authorize Advanced Radiology and/or its affiliated entities to release information from my medical record to: ○ Myself ○ My Representative ○ Healthcare Provider ○ Imaging Center

Institution _____

Name _____

Street Address _____

City _____ State _____ Zip _____

Phone: _____ Fax: _____

Information to be released:

Approximate Date(s) of Exam(s) _____

○ MRI ○ CT Scan ○ PET/CT ○ Nuclear Medicine ○ Ultrasound
○ X-ray ○ Mammogram ○ Bone Densitometry ○ Other _____

Body part imaged: _____

○ Images and Radiologist's Report
○ Images only
○ Radiologist's report only

Format: ○ View via secure email
○ **Compact disc** (images only, reports will be printed)
○ **USB drive**
Please visit www.AdRad.com for fees associated with each format and delivery method.

Notes: _____

_____

_____

MRN (office use only)

I hereby authorize the release of the records described above to myself, my personal representative, my designated healthcare provider, or my designated imaging center. I acknowledge that I have read and understand this authorization agreement.

_____ _____

Signature of Patient or Patient's Authorized Representative Date

_____ _____

Authorized Representative (Please print name) Relationship to Patient

If signed by the patient's representative, please specify the representative's relationship to the patient and authority to act on their behalf. If the patient is a minor (less than 18 years of age) or has a legal guardian, in most cases this authorization must be signed by the patient's parent or legal guardian. If the hospital/provider determines that the minor's consent is necessary to release the requested records, the hospital/provider will contact the minor to obtain his/her authorization.