

### Authorization For Release of Radiology Images and Reports

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ MR# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone Number \_\_\_\_\_

 I, \_\_\_\_\_ hereby authorize **Munson Healthcare Radiology Department**  
(Name)

its Director designee, or Health Information Department, to release information contained in my patient records listed below:

 To \_\_\_\_\_ Attention \_\_\_\_\_  
(Name of person(s) or organization to whom disclosure is to be made)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Email \_\_\_\_\_

- RELEASE OF IMAGES FOR CONTINUATION OF CARE**       **INCLUDING COPY OF INTERPRETATION REPORT**  
 **PATIENT REQUEST FOR PERSONAL USE**  
 **CONSULT** (Release of images for a consultation outside of the Munson Healthcare system. These images are the property of Munson Healthcare; charges may apply for a CD.)

**DATE(S) AND TYPE OF IMAGE(S) TO BE RELEASED:**

- I understand that my radiology file may contain reports and images that only a physician can interpret.
- I understand that I should contact my physician with any questions regarding my radiology file.
- I agree that Munson is not responsible for any misinterpretation of the information in my medical record as a result of not having consulted my physician for the correct interpretation.
- I can revoke (cancel) this Authorization at any time, except in circumstances in which the facility has taken actions in response to this Authorization. I understand this revocation must be submitted in writing.

**This Authorization will expire one year from the date of signing or otherwise by my choice, in which case this consent will expire on:**

 \_\_\_\_\_  
(Date)

Patient/other legal guardian or personal representative signature \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

**Relationship to patient**  *if patient is a minor or incapable of signing, a copy of appropriate legal documentation is attached, if applicable*

INTERNAL USE ONLY BELOW THIS LINE

 Request completed by: \_\_\_\_\_  
Name Dept. Date
 Identification verified by driver's license/or other means: \_\_\_\_\_  
Name Dept. Date