MUNSON HEALTHCARE

Form 3161 (07/23)

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)

it's 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)

Please print and sign - digital signatures not available at this time. This message will not appear when printed

_____ _____ _____

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: **Internal Use Only**

Name Dept. Date

☐ Identification verified by driver's license/or other means: _____ _____ _____

Name Dept. Date