ONSITE RADIOLOGIST
AUTHORIZATION TO RELEASE MEDICAL INFORMATION

ONSITE RADIOLOGIST MRI – CT – Ultrasound www.onsiteradiologist.com info@onsiteradiologist.com	3547 Peachtree Industrial Blvd. Suite#4 Duluth GA 30096 770-299-1332 770-741-0097

PATIENT INFORMATION			
Patient's Name:		DOB:	Sex:
Street address:		City:	State:
Zip Code:	Cell Phone:	Home Phone:	

I authorize the release of the following protected health information:

☐ Radiology Reports and Images ☐ Other:

Please release Medical Information to the following Recipient:

MEDICAL INFORMATION RECIPIENT INFORMATION			
Person/ Organization Name:			
Street address:		City:	State:
Zip Code:	Phone:	Fax:	

Purpose of disclosure:

☐ Medical Care/ Treatment ☐ Other(specify) ____________________________________

I understand that:

- By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.
- I may refuse to sign this authorization, which will not affect my treatment or payment for health care.
- I may revoke this authorization at any time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.
- If the receiving party is not subject to medical records privacy laws, the information may be redisclosed by the recipient and may no longer be protected by federal or state law. Columbia University Medical Center shall not be held liable for any consequences resulting from re-disclosure
- If the information to be released contains any information about HIV/AIDS an additional HIPAA release of medical information for will be requested. • Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.
- A copy of this signed form will be provided to me.
- ONSITE RADIOLOGIST may charge an administrative fee to cover the cost of labor, copying, and postage. The physician's office will inform me of any charges and arrange for payment.
- This Authorization expires on __ / __ / __ {if date not completed / one year after signed}.

______________________________ ______________________________

Patient/ Representative Signature Date

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

______________________________ ______________________________

Print Name Relationship to Patient

Retain this form in the patient's medical record and provide a copy to the patient.