Frederick Health Imaging
400 West Seventh Street Frederick, MD 21701-4593
Phone: 240-566-3420 Fax: 240-566-3255

Authorization to Release Diagnostic Images

Patient Name: _____ **Date of Birth:** _____
Address: _____

Service Date(s): _____

Medical Information to be Released:

- ☐ Mammograms
- ☐ X-Rays
- ☐ MRI
- ☐ CT
- ☐ Ultrasound/Sonogram
- ☐ Nuclear Medicine
- ☐ PET
- ☐ Special Procedure
- ☐ Other: _____

What are you requesting?

- ☐ CD
- ☐ Report Only

Would you like this information mailed to you? If yes, please enter the address you would like them mailed and fax this form:

_____

Imaging reports and/or imaging studies may be requested by walk-in at the Frederick Health Village location-Medical Records Department Monday- Friday between the hours of 8:00am-3:30pm. A photo ID is required.

I hereby authorize Frederick Health to release medical record information to:

Name of Person/Organization: _____

Address: _____

City: _____State: _____Zip Code: _____

Reason for Request:

☐ Continuation of Care ☐ Legal ☐ Personal Use

I understand I may revoke this authorization at any time by notifying Frederick Health Imaging Department in writing. I understand the revocation does not apply to information that has already been released in response to this authorization. Unless revoked, this authorization will expire twelve (12) months from the date of this authorization.

I understand that the information in my medical record may include information about my medical history, diagnoses and/or treatment. I authorize the disclosure of this specific information listed above. I understand that the recipient may re-disclose my medical information, and that it may no longer be protected by federal privacy laws.

I understand there may be a fee for releasing these records which is in accordance with Maryland Law. Once records are released, Frederick Health cannot prevent them from being released to a third party. To be valid this form must be filled out completely and signed. A copy is valid if it has not been altered.

Special Designee:
I hereby authorize _____ **to accept delivery of my medical imaging information.**
Name/Relationship

Name of Patient (please print): _____

Patient Signature: _____**Date:** _____

Designee Signature: _____**Date:** _____

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ For Radiology Use Only ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Identification verification completed by: _____Date:_____

□ Picked Up □ Mailed/Faxed On: _____Initial: _____MRN:_____
Acct # _____

MR.CONSRAD972