WHITE-WILSON
MEDICAL CENTER, P.A.

GW ID: _____

# RELEASE OF RADIOLOGY RECORDS

Patient's Name: _____ Date of Birth: _____

I hereby authorize White-Wilson Medical Center, P.A. to disclose the following Protected Health Information pertaining to the above referenced patient to:

Name of Person or Entity: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: _____ Fax Number: _____

Please release the following studies with radiology reports:

| | | | |
|---|---|---|---|
| _____ Plain Films | Date(s) _____ | ____ Nuclear Medicine | Date(s)_____ |
| _____ MRI Scans | Date(s) _____ | _____Mammography | Date(s)_____ |
| _____ Ultrasound | Date(s) _____ | _____DEXA Scans | Date(s)_____ |
| _____CT Studies | Date(s) _____ | _____Reports Only | Date(s)_____ |

_____

I understand that, if this information is disclosed to a third party, the information may no longer be protected by Federal Privacy Regulations and may be re-disclosed by the person or entity that receives the information.

_____ _____
Signature Date

_____ _____
Printed Name Relationship (If not patient)

_____ _____
X-Ray Number (office use) Released by/Date

**Please Note:** Radiology records will only be released with written authorization by the patient, the patient's guardian, or by subpoena. Radiology records are released only during normal business hours and require 48 hour prior notice.