Atrius Health
Part of Optum®

**Patient Instructions and Information:**
- Please complete this form and mail or fax to former healthcare provider to request your radiology images/CD.

## AUTHORIZATION TO OBTAIN RADIOLOGY IMAGES

Patient's Name: _____ Date of Birth: _____
(Please Print)

Address: _____
Street City State Zip Telephone No.

I do hereby, authorize _____
Name of Facility

Located at _____
Street City State Zip

To release radiology images/CD's of the above named patient to the following Atrius Health Site:

| | | |
|---|---|---|
| **Atrius Health – Chelmsford**<br>228 Billerica Road<br>Chelmsford MA 01824<br>Ph: 978-250-6280 Fax: 978-250-6309 | **Atrius Health – Dedham**<br>1 Lyons Street<br>Dedham, MA 02026<br>Ph: 782-493-3770 Fax: 781-407-7752 | **Atrius Health – Easton**<br>21 Bristol Drive<br>Easton, MA 02375<br>Ph: 617-421-2800 x35916 Fax: 774-302-5740 |
| **Atrius Health – Kenmore**<br>**Attn: Mammography**<br>133 Brookline Ave<br>Boston, MA 02215<br>Ph: 617-421-8990 Fax: 617-421-2134 | **Atrius Health – Somerville**<br>40 Holland Street<br>Somerville, MA 02144<br>Ph: 617-629-6150 Fax: 617-629-6158 | **Atrius Health – Weymouth**<br>51 Performance Drive<br>Weymouth, MA 02189<br>Ph: 781-682-0550 Fax: 781-682-0565 |

**Radiology Images to be released:**
☐ Mammogram ☐ MRI ☐ US ☐ CT ☐ X-Ray ☐ Other: _____

Dates of Images to be released: _____to _____

**Format to be released to Requestor:**
☐ Ambra (employee use only) ☐ CD ☐ Other: _____

**Purpose of Release:** ☐ Medical Care ☐ Other: _____

**HIPAA REGULATIONS PERMIT THE RELEASE OF MEDICAL INFORMATION AND IMAGES BETWEEN TWO FACILITIES PROVIDING CARE TO A PATIENT WITHOUT REQUIRING THE PATIENT'S WRITTEN CONSENT.**

I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not redisclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke this Authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that this authorization will expire in 90 days from the date of said authorization unless I provide a written notice of revocation to the releasing facility noted above.

_____
Signature of Patient or Authorized Representative Date

_____
Printed Name of Patient or Authorized Representative Relationship to Patient