Atrius Health
Part of Optum®

Delivery Instructions	For Internal Use
☐ Pick up --	
Name of person picking up records:	_____
(if other than patient or authorized representative)	
Pick up Location:	_____
☐ Prepared by_____	Date: _____

AUTHORIZATION TO RELEASE RADIOLOGY IMAGES

Patient's Name: _____ DOB: _____MR# _____
(Please Print)

Address: _____
Street City State Zip Telephone No.

I hereby authorize Atrius Health to release the Radiology images selected below, of the above-named patient to the following person or facility:

_____
Name of Person or Facility

_____
Street City State Zip

Purpose of Release:

❑ Medical Care ❑ Legal ❑ Insurance ❑ Personal ❑ Leaving Atrius ❑ Other: _____

Radiology Images to be released:

❑ Mammogram ❑ MRI ❑ CT ❑ X-Ray ❑ Other:_____

_____
Date(s) of Images to be released

***Please note*: - Copies of images do not need to be returned to Atrius. Processing fees may apply.**

I understand that:

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at Atrius Health unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
- I may revoke this authorization at any time by submitting a written notice of revocation to Atrius Health. The revocation will be effective upon Atrius Health's receipt of my written notice, except that it will not have any effect on any action already taken by Atrius Health in reliance on this authorization.
- Once Atrius Health has disclosed my health information to the recipient, Atrius Health cannot guarantee that the recipient will not redisclose my health information to a third party.
- This authorization will automatically expire 90 days from the date set forth below unless otherwise specified:

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Authorized Representative Relationship to Patient

Send Completed Form to Medical Records