NON-BREAST IMAGING REQUEST OF COMPASS MEDICAL via JEFFERSON RADIOLOGY
IMAGING RELEASE FORM

☐ I have had non-breast imaging at the following imaging facility:

IMAGING FACILITY (Name) _____

Address _____

_____

☐ I am unsure of the imaging facility or location. My current health care provider is: _____

_____

☐ My records may be under a different name: _____

This authorization is voluntary. This authorization is a one-time allowance for Jefferson Radiology to release my images that were performed at Compass Medical. This is not a guarantee that my images or reports will be available since these are Compass Medical's medical records and Jefferson Radiology was not contracted to archive Compass's records.

I understand that the information released pursuant to this authorization may no longer be protected by law or regulation and may be re-disclosed by the recipient.

AUTHORIZATION

PATIENT NAME (print): _____ DOB: _____

PATIENT SIGNATURE: _____DATE: _____

Please forward an unencrypted DICOM CD along with the corresponding reports for any imaging studies of (What body location – L Knee, R Hip etc)_____

If a Medical Facility is requesting and can utilize image share; image share will be the primary mode.

Please send the **image (including report) share** request to **email**

imagerequest@atriushealth.org

If hardcopies, please mail the image/report to:

Atrius Health
Diagnostic Testing Center—First Floor
330 Brookline Ave
Boston, MA 02215