Atrius Health

Dedham Medical Associates
Granite Medical Group
Harvard Vanguard Medical Associates

Delivery Instructions **For Internal Use**

- ❑ Pick up --
  Name of person picking up records: _____
  (if other than patient or authorized representative)
  Pick up Location: _____
- ❑ Signed out in RIS
- ❑ Prepared by_____ Date: _____

AUTHORIZATION TO RELEASE RADIOLOGY FILMS/IMAGES

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

Address: _____
Street City State Zip Telephone No.

I hereby authorize Atrius Health to release the radiology films/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 Health ❑ Other:_____

Radiology Films/Images to be Released:

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

_____
Date(s) of Films/Images to be Released

<u>Please note</u>: - Copies of films/images do not need to be returned to Atrius Health. <u>Originals must be returned within 30 days.</u>
- Processing fees may apply.

<u>Release of Original Films</u>:

I understand that the radiology films to be released are originals and that no copies may exist. I understand that I must return these radiology films to Atruis Health within 30 days. I hereby release Atruis Health and its employees and agents from any and all liability that may arise from the release of the requested radiology films or from the failure to return the radiology films.

_____ _____ _____
Signature of Patient or Authorized Representative Date Relationship to Patient

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 at the address listed above. 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