ASSOCIATION OF ALEXANDRIA RADIOLOGISTS, PC

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION – MEDICAL RECORDS RELEASE

alexandriaradiology.com

ALEXANDRIA IMAGING CENTER
4660 Kenmore Avenue, Suite 525
Alexandria, VA 22304
P 703.751.5055 F 703.370-3889

WOODBRIDGE IMAGING CENTER
4001 Prince William Parkway, Suite 302
Woodbridge, VA 22193
P 703.494.3309 F 703.357.9636

Patient Name: _____
LAST FIRST MIDDLE

Address: _____
NUMBER & STREET CITY ZIP

Phone Numbers (Home) _____ (Cell) _____

If you have medical records at another facility that Association of Alexandria Radiologists, LLC needs to obtain please fill out the sign below:

I hereby authorize the release of my medical records to the facility listed checked above from:

Facility _____ Phone _____ Fax _____

☐ All imaged data and reports ☐ Specific study(ies) ☐ Permanent release of mammography

If you would like us to release or disclose your results and/or imaging studies and reports to a third party release, another facility, or a family member please fill out and sign below:

I further authorize the disclosure of my radiology medical records from any Association of Alexandria Radiologists, LLC to the following 3rd party individual(s):

Name: _____ Relationship: ◯ Spouse ◯ Child ◯ Other

Address: _____
NUMBER & STREET CITY ZIP

Phone Numbers (Home) _____(Cell) _____

☐ Film/CD (1) Study _____ Date _____/(2) Study _____ Date _____

☐ Report (1) Study _____ Date _____/(2) Study _____ Date _____

☐ Other _____ Date _____

Released to: _____ Date _____

This authorization can be revoked at any time with written notification. This authorization expires one year from the date signed.

_____ Date: _____
PATIENT (OR GUARDIAN) SIGNATURE

If not signed by the patient, please indicate the relationship: Proof of identity required. ◯ Parent/Guardian
◯ Beneficiary/personal representative of deceased patient ◯ Guardian/conservator of an incompetent patient

Please note, there is no charge for the first CD copy. Additional CD copies are available for a fee of $7.00. Copies of films, if available, are $7.00/sheet.

FOR OFFICE USE ONLY Date Request Taken _____ By _____ Date Picked Up _____ By _____

Date Mailed Out _____ By _____ # of Films Signed Out _____ Identification Presented _____

SUBMIT