

AUTHORIZATION TO DISCLOSE/RELEASE MEDICAL RECORDS

PLEASE PRINT ALL INFORMATION

Patient Name: _____
(First) (Last)

Date of Birth: mm/dd/yyyy / / SSN#:

Phone#: _____

Exam: (Please check the exam(s) to which you are requesting reports/films)

CT PET/CT CTA

Date of Exam: mm/dd/yyyy / /

Are you requesting REPORTS FILMS

- If you are requesting REPORTS, please indicate how you would like to receive them:
 Fax Mail Collect in person Email
- If you are requesting FILMS, please indicate how would you like to receive them:
 Mail Collect in person CD send by mail
 who would you like to receive your reports/films. Collect in person
- You Referring Physician Another Physician Other

- If you would like your reports/films to be sent to you, please fill out the below information:
Patient Mailing Address: _____
Phone# _____ Fax# _____ email: _____

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- If you would like your reports/films to be sent to your referring physician, please fill out the below information:

Referring Physician Name: _____

Mailing Address: _____

Phone#: _____ Fax: _____

- If you would like your reports/films to be sent to another physician or (other), please fill out the information below:

Name: _____

Mailing Address: _____

Phone#: _____ Fax: _____

I authorize the release of my medical records as indicated above. I understand the release of these films/reports will no longer preserve the confidentiality of my records and the information contained therein. I hereby release NY Medscan Diagnostic Imaging, and all of their personnel, both technical and administrative, from any and all liability claims, demands and actions of any kind, which may arise or result from the release of these films/reports.

PATIENTS SIGNATURE: _____

DATE: _____

PLEASE NOTE:

- Your request will be ready for collection/mailing approximately 3 days from date of request. Please allow normal time for mailing
- Our medical records department will contact you (between 9am – 5pm) when your films are printed to advise you of the cost. The cost of printing your case is determined by the number of film sheets used. This number can vary greatly. It is not possible for us to determine this number in advance of printing your case.

751 Second Avenue

New York, NY 10017

Phone: 212.599.5555

Fax: 212.599.5554

Website: www.nymedscan.com

- Please refer to www.nymedscan.com for more important information regarding your request.

WHEN COMPLETED PLEASE FAX THIS FORM TO 212.599.5554