FREDERICK MEMORIAL HEALTHCARE SYSTEM
400 West Seventh Street Frederick, Maryland 21701-4593
Phone: 240-566-3420 Fax: 240-566-3255

Authorization to Release Diagnostic Images

Patient Name: _____ **Date of Birth:** _____
Address: _____
Service Date(s): _____

Medical Information to be Released:

☐ Mammograms	☐ CT	☐ PET
☐ X-Rays	☐ Ultrasound/Sonogram	☐ Special Procedure
☐ MRI	☐ Nuclear Medicine	☐ Other: _____

What are you requesting?

☐ Paper film copy ☐ CD ☐ Report Only

Would you like to pick up requested information? If yes, at what facility?

☐ Rosehill ☐ Crestwood

Would you like this information mailed to you? If yes, please enter the address you would like them mailed:

_____

Radiology reports and/or imaging studies may be picked up at the above facilities Monday–Friday between 8:00 a.m. – 5:00 p.m., we request at least 24 hours notice.

I hereby authorize FMH to release medical record information to:

Name of Person/Organization: _____
Address: _____
City: _____State: _____Zip Code: _____

Reason for Request:

☐ Continuation of Care ☐ Legal ☐ Personal Use

I understand I may revoke this authorization at any time by notifying Frederick Memorial Hospital Radiology Department in writing. I understand the revocation does not apply to information that has already been released in response to this authorization.

I understand that the information in my medical record may include information about my medical history, diagnoses and/or treatment. I authorize the disclosure of this specific information listed above. I understand that the recipient may re-disclose my medical information, and that it may no longer be protected by federal privacy laws.

I understand there may be a fee for releasing these records which is in accordance with Maryland Law. Once records are released, Frederick Memorial Hospital cannot prevent them from being released t o a third party. To be valid this form must be filled out completely and signed. A copy is valid if it has not been altered.

Special Designee:
I hereby authorize _____ **to accept delivery of my medical imaging information.**
Name/Relationship

Name of Patient (please print): _____

Patient Signature: _____**Date:** _____

Designee Signature: _____**Date:** _____

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ For Radiology Use Only ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Identification verification completed by: _____Date:_____

☐ Picked Up ☐ Mailed/Faxed On: _____Initial: _____MRN:_____
Acct # _____

MR.CONSRAD972