



Records Authorization Form

Staff's Initials \_\_\_\_\_ Today's Date \_\_\_\_\_ Date and Time of Pick Up \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date Last Seen \_\_\_\_\_

Account Number \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Patient Pickup  Delivery  Physician Pickup  Fax # \_\_\_\_\_  Other \_\_\_\_\_

Method of Mailing:  USPS  FedEx  UPS  DHL  Other \_\_\_\_\_

Request: *Check all that apply*  Report  Film  CD Charge for mailing/film/CD: \$ \_\_\_\_\_

I authorize WRA to release  Exam(s) \_\_\_\_\_  Complete records to:

Name of Doctor/Hospital \_\_\_\_\_ Department \_\_\_\_\_

Number and Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

I am requesting \_\_\_\_\_  
Physician or hospital from which you are requesting your records

Name of Doctor/Hospital \_\_\_\_\_ Department \_\_\_\_\_

Phone Number \_\_\_\_\_

To release my previous imaging studies (including films or CDs), \_\_\_\_\_ and a copy of the results to the WRA office location listed below.

- 2141 K Street, NW #900, Washington, DC 20037, 202-223-9723
- 2175 K Street, NW #C-150, Washington, DC 20037, 202-223-1566
- 2021 K Street, NW #T-120, Washington, DC 20006, 202-466-2033
- 3022 Williams Drive, #200, Fairfax, VA 22031, 703-698-8800
- 21351 Ridgetop Circle, #100, Sterling, VA 20166, 571-434-0140
- 10215 Fernwood Road, #50, Bethesda, MD 20817, 301-564-1053
- 4445 Willard Avenue, #200, Chevy Chase, MD 20815, 301-654-4242



Records Authorization Form Continued...

Prepared by (employee's initials) \_\_\_\_\_ Logged Out \_\_\_\_\_ Date \_\_\_\_\_

Table with 6 columns: Exam(s) Date, Type of Exam, # of Films/CD, Exam(s) Date, Type of Exam, # of Films/CD. Multiple rows for data entry.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to WRA at 3015 Williams Drive, #200, Fairfax, VA 22031. I understand that a revocation is not effective for prior disclosures of protected health information made with the authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

- Radio button options: I am borrowing original films... I have received copies of the films/CDs. They do not need to be returned to WRA.

Patient's Signature or Person taking films if other than patient:

\_\_\_\_\_  
Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_ Authorization will expire in 90 days from "Today's Date."

Top Copy - Original/File

Bottom Copy - Patient