WASHINGTON RADIOLOGY

REQUEST FOR RELEASE OF IMAGES AND REPORTS

Please fill out the form below and submit to us by fax or email

Fax: (703)280-1527 Email: medicalrecords@washingtonradiology.com

Patent information

Patient Name: _____

Previous/ Maiden Name: _____

Date of Birth: _____ **Telephone Number:** _____

Receiving Party

I authorize Washington Radiology to release the following information to:

_____

Name of Person or Entity to receive information

_____

Street Address City State Zip code

Information to be released

Dates of treatment:

_____

_____

- ☐ **Mammograms**
- ☐ **MRI**
- ☐ **CT**
- ☐ **Ultrasounds**
- ☐ **X-Rays**
- ☐ **Bone Density Scan**
- ☐ **Other:** _____

be sure to select one or both options

- ☐ **Radiology Images on a disk**
- ☐ **Imaging Reports**

Method of delivery *select one option only- if necessary, please submit additional requests*

- ☐ **Mail records to the address above**
- ☐ **Email reports to:** _____ **email only applies to reports, we cannot email radiology images.*
- ☐ **Fax reports to:** _____ ** fax only applies to reports, we cannot fax radiology images*
- ☐ **I will pick records up from:**

_____

Washington Radiology Location

Protected Health Information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present, or future health and related health care services. Consistent with our Notice of Privacy Practices, Solis Mammography/Washington Radiology is required to obtain your authorization to permit the following use or disclosure of your PHI for purposes other than treatment, payment and health care operations. Solis Mammography/Washington Radiology will not condition its provision of services to you on whether you provide authorization for the requested use or disclosure. I understand that I may inspect or obtain a copy of the PHI of which I am being asked to allow the use or disclosure. I understand that I have the right to revoke this authorization at any time by sending such written notification to our Privacy Official via mail to Solis Mammography, Attn: Privacy Officer, 15601 Dallas Parkway, Suite 300, Addison, Texas 75001. Such a revocation will not be effective to the extent that Solis Mammography/Washington Radiology has relied on it for the previous use or disclosure of the PHI. If I sign this Authorization, I have a right to receive a signed copy of it. 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. This Authorization shall be in force and effective for 1 years from the date of my signature or until I revoke or terminate my authorization in writing, whichever is later, at which time Solis Mammography/Washington Radiology authorization to use or disclose the PHI specified expires.

Patient Signature: _____ Date: _____

*must be physically signed