Patient Request for Release of Images and Reports

Washington Radiology Instructions to Patient

Complete this document and send to Washington Radiology by scanning and emailing, or by faxing, to Washington Radiology by using the contact details below.

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

Thank you,
Washington Radiology Customer Care

Patient Instructions to Facility

I, _____ (*Previous Last Name - if applicable*)_____

Date of Birth _____ hereby authorize:

Name of Facility: _____

Phone: _____ Fax: _____

Address: _____

City, State, Zip: _____

Images being requested: _____

To release my images and reports to:

Washington Radiology Medical Records Department
3022 Williams Dr, Suite 102
Fairfax, VA 22031
Phone: (703) 280-1397
Fax: (703) 280-1527

Patient Signature: _____ Date: _____

Patient Phone number: _____

Washington Radiology Instructions to Facility

Our patient has requested the transfer of his/her images and reports to Washington Radiology as soon as possible for patient care purposes.

Please notify us immediately if you do not have the requested images and reports.

Thank you,
Washington Radiology Customer Care