

Authorization to release confidential medical information form

Congratulations on taking the first step in owning your health! A Heart Scan can help you identify risks early so that you can take action now.

***By completing the Authorization to Release Confidential Medical Information form that follows, you are giving Medical Imaging of Fredericksburg, LLC permission to send your results to the provider(s) of our choice.***

***Although your heart scan did not require a written order from your physician, we strongly encourage you to share and discuss your score with them as this is critical information that is useful in defining your risks and directing a treatment plan, when needed. This form will also serve as documentation of how you want to receive your results.***

Sincerely,

The Health Scan Screening Program at Medical Imaging of Fredericksburg, LLC.

MEDICAL IMAGING OF FREDERICKSBURG

**Authorization to Release Confidential Medical Information**

**Request Date:**

**Pick-up Date/Time:**

Med. Rec. #

**I, DOB**

**(Last Name, First Name)**

**SSN - -**

Address

City

State

Zip Code

Phone ( ) -

authorize Medical Imaging of Fredericksburg to release the information specified below, in accordance with the laws of the

Commonwealth of Virginia, and Mary Washington Healthcare, to the party identified below.

**Doctor/Facility Pick up by:**

Address City State Zip Code

The purpose for the disclosure of the above information is:

 Continuing Care / Personal Use

***Information to be Released***

**Date/Type of exam:**

 **Online Record Delivery (via Rad Connect) e-mail:**

 **Please include Radiology Report**

 **CD Please do NOT return a CD.** It is your personal copy.

CD's requested for personal usage will carry a charge of **$5 per CD**.

 **Outside Films Included MIF Associate Initials**

VA law allows for copy charges consisting of the following: $10.00 administrative fee PLUS $0.50 per page for the first 50 pages and $0.25 per page thereafter, and $1.00 per page of microfilm/fiche.

I hereby authorize, allow, and cause the release of information indicated above. No threat or other coercive measures have induced me to sign this form, and I do release Mary Washington Healthcare from, and covenant not to sue MHS for any claim I have or may have in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits. I may request to

inspect or copy any information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time by notifying the Privacy Officer in writing of my revocation, except where actions have already been taken in reliance upon this authorization. If I do not revoke it earlier, this authorization will expire on the date, event,

or condition described as: (if none specified, this authorization will expire 6 months after the date specified below.)

**Patient Signature: Date: Parent/Guardian/Patient Designee Signature Date:** Authority of Individual Signing for Patient: