MEDICAL IMAGING OF FREDERICKSBURG

Authorization to Release Confidential Medical Information

Request Date: _____ **Pick-up Date/Time:**_____ Med. Rec. # _____

I, _____ **DOB** _____ **SSN** _____ **-** _____ **-** _____

(Last Name, First Name)

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 Nucleus) 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 **$10 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: _____