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 eDelivery 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.

Authorization to Release Information:

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 MWHC 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 as provided in CFR 164.524. 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: ____________________________