MEDICAL IMAGING OF FREDERICKSBURG

Authorization to Release Confidential Medical Information

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

I, _____ DOB _____
(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.

Electronic Transfer via PowerShare to:_____
Name: _____
Pick-Up Date:_____
Organization:_____
Street Address:_____
City, State, Zip:_____
Online Record eDelivery e-mail address:_____

Cost: $10 per CD (if for personal use)
Cost: $20 USB
No Cost: PowerShare

Information to be released:

- ☐ Radiology Reports
- ☐ Consultation
- ☐ Other (Please specify)_____
- ☐ Outside Films Included

Dates of Service_____to_____Medical Record Number_____
MIF Associate Initials_____

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: _____ **Date:** _____

Revised 3/12/2024