RADIOLOGY Regional
A LucidHealth Company

Medical Records Request/Release

Patient Name: _____ Jacket #: _____ Date of Birth: _____

Phone: _____other name(s) on prior studies: _____

REQUEST OUTSIDE IMAGES WITH REPORT TO BE SENT TO RADIOLOGY REGIONAL: ☐ **All Breast Imaging & Reports**

Images/Dates: _____

From Physician/Facility: _____

Address: _____ Fax: _____

Phone: _____ Email: _____

☐ **PowerShare** - share and exchange medical images **(preferred method)**

☐ **Send requested records in DICOM CD format to**:

Radiology Regional
Attn: Medical Records
3670 Broadway Ave. Fort Myers, FL 33901
Phone: (239) 275-3160 Fax: (239) 275-6455

*We do not accept encrypted CDs
***Please include this release with images sent**

☐ **RELEASE OF RADIOLOGY REGIONAL RECORDS TO OUTSIDE FACILITY** ☐ **IMAGES** ☐ **REPORTS** ☐ **POWERSHARE** ☐ **CD**

Images/Dates: _____

To Physician/Facility: _____

Address: _____ Fax: _____

Phone: _____ Email: _____

☐ **POWERSHARE for IMAGES to:** Email: _____, at patients request.

- I understand that I have the right to revoke this Authorization at any time in writing, except to the extent that Radiology Regional Center PA, has already acted in reliance on this Authorization. I can revoke this authorization by providing written revocation to: Radiology Regional Center PA Attn: Privacy Officer, 3660 Broadway Fort Myers, and Fl. 33901.
- I understand that failure to sign this authorization, Radiology Regional Center PA, may not refuse treatment, payment, enrollment, or eligibility of benefits to me.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to applicable privacy laws.
- This Authorization shall be effective for two years or until I revoke it in writing.

****In lieu of patient signature, please process record request as CONTINUATION OF CARE****

_____ _____ _____

Patient or Representative Signature | Printed Name | Date

*Must be parent, legal guardian and/or have written proof of Authorized Representative and a copy of this proof must be attached to this release/request.

PATIENT COPY