Medical Record Request/Release

Patient Name: _____ ID: _____ Date of Birth: _____

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

☐ **RELEASE OF RADIOLOGY REGIONAL IMAGES WITH REPORT TO OUTSIDE FACILITY** ☐ **RELEASE TO PATIENT**

Images/Date: _____

To Physician/Facility: _____

Address: _____ Fax: _____

Phone: _____ Email: _____

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

Images/Dates: _____

From Physician/Facility: _____

Address: _____ Fax: _____

Phone: _____ Email: _____

Send requested records in DICOM CD format to:
***We do not accept encrypted CDs**

Please include this release with images sent

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

- 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 Radiology Regional Center PA, may not condition treatment, payment, enrollment, or eligibility for benefits or whether I sign this Authorization.
- 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.

_____ _____ _____

Signature of Patient or authorized representative* 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.

Revision Date: 1/8/21