



Delivery Instructions	For Internal Use
<input type="checkbox"/> Pick up --	
Name of person picking up records: (if other than patient or authorized representative)	_____
Pick up Location:	_____
<input type="checkbox"/> Signed out in RIS	
<input type="checkbox"/> Prepared by _____	Date: _____

AUTHORIZATION TO RELEASE RADIOLOGY FILMS/IMAGES

Patient's Name: _____ (Please Print) DOB: _____ MR# _____

Address: _____
Street City State Zip Telephone No.

I hereby authorize Harvard Vanguard Medical Associates to release the radiology films/images, selected below, of the above-named patient to the following person or facility:

Name of Person or Facility

Street City State Zip

Purpose of Release:

- Medical Care Legal Insurance Personal Leaving Harvard Vanguard Other: _____

Radiology Films/Images to be Released:

- Mammogram MRI CT X-Ray Other: _____

Date(s) of Films/Images to be Released

Please note: - Copies of films/images do not need to be returned to Harvard Vanguard. **Originals must be returned within 30 days.**
- Processing fees may apply.

Release of Original Films:

I understand that the radiology films to be released are originals and that no copies may exist. I understand that I must return these radiology films to Harvard Vanguard within 30 days. I hereby release Harvard Vanguard and its employees and agents from any and all liability that may arise from the release of the requested radiology films or from the failure to return the radiology films.

Signature of Patient or Authorized Representative

Date

Relationship to Patient

I understand that:

- I may refuse to sign this authorization. I understand that my refusal will not affect my ability to obtain treatment at Harvard Vanguard unless (a) the only purpose of the treatment is to create health information for the disclosure listed above; or (b) if my treatment is related to participation in a research study for which this authorization is required.
- I may revoke this authorization at any time by submitting a written notice of revocation to Harvard Vanguard at the address listed above. The revocation will be effective upon Harvard Vanguard's receipt of my written notice, except that it will not have any effect on any action already taken by Harvard Vanguard in reliance on this authorization.
- Once Harvard Vanguard has disclosed my health information to the recipient, Harvard Vanguard cannot guarantee that the recipient will not disclose my health information to a third party.
- This authorization will automatically expire 90 days from the date set forth below unless otherwise specified: _____

Signature of Patient or Authorized Representative

Date

Printed Name of Patient or Authorized Representative

Relationship to Patient