

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH ____ / ____ / ____
ADDRESS: _____ CITY: _____ STATE: _____
ZIP CODE: _____ PHONE: _____ EMAIL: _____

CLINIC OR HOSPITAL PROVIDER:

**Who is releasing these records? Select one.*

CRL IMAGING SOUTHDAL/WOMEN'S IMAGING CRL IMAGING PLYMOUTH TWIN CITIES MEDICAL IMAGING
 OTHER (please list name): _____

If you selected **OTHER** above, please provide the information below:

PROVIDER ADDRESS: _____ CITY: _____ STATE: _____
ZIP CODE: _____ PHONE: _____ EMAIL: _____

RECEIVING PARTY:

**Who is receiving these records? Select one.*

CRL IMAGING SOUTHDAL/WOMEN'S IMAGING CRL IMAGING PLYMOUTH TWIN CITIES MEDICAL IMAGING
 OTHER (please list name): _____

If you selected **OTHER** above, please provide the information below:

PROVIDER ADDRESS: _____ CITY: _____ STATE: _____
ZIP CODE: _____ PHONE: _____ EMAIL: _____

INFORMATION TO BE RELEASED:

**What do you want sent or released? Select one.*

Copies of Images CD Dates of Service(s) if you don't remember the date put the year(s): _____

WHAT WAS THE SERVICE:

Select one.

CT BONE DENSITY (DXA) FLUOROSCOPY MAMMOGRAM MRI PAIN MANAGEMENT
 ULTRASOUND X-RAY OTHER: _____

DELIVERY OF RECORDS:

HOW DO YOU WANT TO RECEIVE THE INFORMATION? SELECT ONE:

MAIL PICK-UP AT CLINIC SELF/REPRESENTATIVE OTHER: _____

WHEN ARE THE RECORDS NEEDED BY? ____ / ____ / ____

TERMS & CONDITIONS: This authorization lasts for one year after the date it is signed. This authorization may be cancelled in writing at ANYTIME. A cancellation will not change the releases that happen prior to the time the cancellation notice is received. TO CANCEL A RELEASE, call or send a request to the "Requested Release Form" address above. A photocopy or fax of this authorization will be treated the same as an original. Consulting Radiologists, Ltd. and its affiliates; CRL Imaging, CRL Women's Imaging, LifeScan Minnesota, and Twin Cities Medical Imaging CANNOT prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by the State and Federal privacy protections once it is released. By signing the document below, you release Consulting Radiologists, Ltd. and its affiliates; CRL Imaging, CRL Women's Imaging, LifeScan Minnesota, and Twin Cities Medical Imaging from any liability from a re-disclosure by the recipient. Consulting Radiologists, Ltd. and its affiliates; CRL Imaging, CRL Women's Imaging, LifeScan Minnesota, and Twin Cities Medical Imaging WILL NOT condition treatment on whether you sign this form. **By signing below, this form indicates that you have read and understand this form, authorize release of your information as described above.**

SIGNATURE: _____ DATE: ____ / ____ / ____