CRL Consulting Radiologists Ltd.

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 SOUTHDALE / WOMEN'S IMAGING
6525 France Ave South, Suite 110
Edina, MN 55435
P 952.915.4320 F 952.915.4338

( ) CRL IMAGING PLYMOUTH
15700 37th Ave North, Suite 100
Plymouth, MN 55446
P 763.509.4720 F 763.509.4738

( ) 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.*

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( ) 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.*

( ) Images ( ) Reports 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) ( ) MAMMOGRAM ( ) MRI ( ) 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: _____ / _____ / ________