Atrius Health

Dedham Medical Associates
Granite Medical Group
Harvard Vanguard Medical Associates

Patient Instructions and Information:

- Please complete this form and mail or fax to former healthcare provider to request your radiology films/images/CD's.

AUTHORIZATION TO OBTAIN RADIOLOGY FILMS/IMAGES/CD's

Patient's Name: _____ Date of Birth: _____
(Please Print)

Address: _____
Street City State Zip Telephone No.

I do hereby, authorize _____
Name of Physician, Facility or Person

Located at _____
Street City State Zip

to release radiology films/images/CD's of the above named patient to the following Atrius Health facility:

Atrius Health

_____
Street

_____
City State Zip

Radiology Films/Images/CD's to be Released:

☐ Mammogram ☐ MRI ☐ CT ☐ X-Ray ☐ Other: _____

Dates of Films/Images/CD's to be Released: _____to _____

Format to be Released to Requestor:

☐ Films ☐ CD's ☐ Other: _____

Purpose of Release: ☐ Medical Care ☐ Other: _____

I understand that once this health information is disclosed, the releasing facility cannot guarantee that the recipient will not redisclose my health information to a third party. Such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I understand that I may refuse to sign or may revoke this Authorization in writing at any time and for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment. I understand that this authorization will expire in 90 days from the date of said authorization unless I provide a written notice of revocation to the releasing facility noted above.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Printed Name of Patient or Authorized Representative Relationship to Patient