Advanced Radiology Health Information Management
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Medical.Records@AdRad.com

INFORMATION RELEASE AUTHORIZATION - OUTGOING

Patient Name _____ Date of Birth _____

Telephone _____

Patient Email _____

Street Address _____

City _____ State _____ Zip _____

I hereby authorize Advanced Radiology and/or its affiliated entities to release information from my medical record to: ◯ Myself ◯ My Representative ◯ Healthcare Provider ◯ Imaging Center

Institution _____

Name _____

Street Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Inst. Email _____

Information to be released: ◯ Images and Radiologist's Report ◯ Images only ◯ Report Only

Approximate Date(s) of Exam(s) _____

Exam Type:
☐ MRI ☐ CT Scan ☐ PET/CT ☐ Nuclear Medicine ☐ Ultrasound
☐ X-ray ☐ Mammogram ☐ Bone Densitometry ☐ Other _____

Body Part Imaged: _____

Format: ◯ View via secure email
◉ **Compact disc** (images only, reports will be printed) ◯ **PowerShare**
Please visit www.AdRad.com for fees associated with each format and delivery method.

Pick-up Location:
◯ Fairfield ◯ Shelton (Clinical) ◯ Shelton (Business Office) ◯ Orange
◯ Stamford ◯ Stratford ◯ Trumbull ◯ AWIC ◯ Wilton

Notes: _____

MRN (office use only)

I hereby authorize the release of the records described above to myself, my personal representative, my designated healthcare provider, or my designated imaging center. I acknowledge that I have read and understand this authorization agreement.

_____ _____

Signature of Patient or Patient's Authorized Representative — Date

_____ _____

Authorized Representative (Please print name) — Relationship to Patient

If signed by the patient's representative, please specify the representative's relationship to the patient and authority to act on their behalf. If the patient is a minor (less than 18 years of age) or has a legal guardian, in most cases this authorization must be signed by the patient's parent or legal guardian. If the hospital/provider determines that the minor's consent is necessary to release the requested records, the hospital/provider will contact the minor to obtain his/her authorization.