Advanced Radiology

INFORMATION RELEASE AUTHORIZATION - INCOMING

Patient Name _____ Date of Birth _____

Telephone _____

Street Address _____

City _____ State _____ Zip _____

I hereby authorize the following information to be released to Advanced Radiology Consultants and its affiliated entities from:

Individual / Institution: _____

Exams Requested / Dates _____

Information to be released:

○ Laboratory Reports ○ Imaging Reports ○ Imaging Studies (preferably by CD)
○ Pathology Reports ○ Operative Reports

Please forward requested information to:

☐ Fairfield
1055 Post Road, Fairfield, CT 06824
Phone: 203.319.3650
Fax: 203.256.3258

☐ Orange
297 Boston Post Road, Orange, CT 06477
Phone: 203.891.1690
Fax: 203.891.1693

☐ Shelton
4 Corporate Drive, Suite 182, Shelton, CT 06484
Phone: 203.926.6888
Fax: 203.926.6954

☐ Stamford
1259 East Main Street, Stamford, CT 06902
Phone: 203.316.2710
Fax: 203.356.9836

☐ Stratford
2876 Main Street, Stratford, CT 06614
Phone: 203.380.3740
Fax: 203.375.9452

☐ Advanced Interventional Radiology
1055 Post Road, Suite 150, Fairfield, CT 06824
Phone: 203.386.3164
Fax: 203.380.3252

☐ Trumbull
15 Corporate Drive, Trumbull, CT 06611
Phone: 203.452.2244
Fax: 203.459.0116

☐ Advanced Women's Imaging Center
15 Corporate Drive, Trumbull, CT 06611
Phone: 203.452.6266
Fax: 203.452.6267

☐ Wilton
60 Danbury Road, Suite 102, Wilton, CT 06897
Phone: 203.891.1515
Fax: 203.665.9730

☐ Advanced Radiology Health Information Management
1 Corporate Drive, Suite 325, Shelton, CT 06484
Phone: 203.380.3284
Fax: 203.380.3289

As part of our Quality Assurance Program, we make every effort to correlate biopsy results. Do we have permission to obtain biopsy results from your doctor/hospital? ○ Yes ○ No

Authorization expires _____/ _____ / _____/ If blank, auth. expires 12 mos. from date of signature

I hereby authorize that the records described above may be released to or recieved by Advanced Radiology Consultants and its affiliated entities. I understand that I am not required to sign this authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on the authorization. The revocation letter should be sent to Advanced Radiology Consultants, 1 Corporate Drive, Suite 325, Shelton, CT, 06484. By signing below, 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.