MEDICAL RECORDS RELEASE FORM

To further insure compliance with the “Health Insurance Portability Act of 1996”, River Radiology requests your written authorization to release health care information to outside health care facilities and send results to specific health care providers at the discretion of the patient.

COMPLETION OF THE FOLLOWING INFORMATION IS ESSENTIAL TO UPDATE OUR PROVIDER DATA BASE AND PROCESS YOUR REQUEST.

I, ______________________________ (Patient Name) authorize River Radiology to release copies of my clinical records, including films, and/or original mammograms in connection with my care and treatment on ____ (Date) to the following:

1) **Doctor's Full Name**: ____
   Complete Mailing Address: ____
   Phone Number: (_____)____________________ Fax Number: (_____)____________________

2) **Doctor's Full Name**: ____
   Complete Mailing Address: ____
   Phone Number: (_____)____________________ Fax Number: (_____)____________________

3) **Doctor's Full Name**: ____
   Complete Mailing Address: ____
   Phone Number: (_____)____________________ Fax Number: (_____)____________________

Patient's Signature: ____ Date: _____/_____/________

Legal Guardian: ____ Date: _____/_____/________

Witness: ____ Date: _____/_____/________

FOR STAFF USE:

UPIN # ______________________________ **FAX # (______)** _________________________

MEDICAID # __________________**If not PAR with MEDICAID, LICENSE #** ____________________

Database Entry _______________________________ **Date:** ______/______/_______
River Radiology Staff

Revised 7/01/09