AUTHORIZATION FOR THE RELEASE OF RADIOLOGY EXAMS

PATIENT/PHYSICIAN MUST COMPLETE THIS AUTHORIZATION WHEN REQUESTING COPIES OF RADIOLOGY IMAGES AND/OR REPORTS

Date Requested: ____________ Needed by: ____________ Phone Number: ____________

Last Name ____________ First Name ____________ DOB: ____________

I authorize Orthopaedic & Sports Medicine Specialists to disclose a copy of my radiology exam(s)/report to: ____________

WRITTEN APRROVAL FOR RELEASE OF EXAMS:

1. EXAM(S) to be released:

DATE OF STUDY	TYPE OF STUDY / # CD	Report included	Prepared By / Released By
DATE OF STUDY	TYPE OF STUDY / # CD	Report included	Prepared By / Released By

Purpose of Disclosure

☐ Medical Care ☐ Legal ☐ Insurance ☐ Other

If other, please specify ____________

IMAGES BEING TAKEN TO: ____________

2. I understand that if my medical records contain information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexual transmitted or communicable disease, AIDS, tuberculosis or test for infection with human immunodeficiency virus (HIV), I am aware that New Jersey has a statutory privilege afforded to confidential communication between patient and a licensed physician or psychologist and that my signing this form waives this privilege.
3. I acknowledge and understand that use and disclosure of my health information authorized by this document may be subject to re-disclosure by the recipient and not be protected by privacy and confidentiality law.
4. I understand that I will be charged for additional copies of my radiology exam(s) on CD which may include shipping and handling ($5.00 per CD).

Print your full name and sign:

X ____________ Ip Address

Relationship, if not Patient ____________

Number of CDs burned (@ $5.00 ea.): ____________ Cash: ____________ Check #: ____________

Credit card: ____________ Total $ ____________