South Shore Health

Radiology
Tel: 781-624-8906
Fax: 781-624-3356
Email: PDLDIFilmLibrary@southshorehealth.org

Authorization to Release Radiology Diagnostic Images/Reports

1. Patient's Name: _____ **2.** Date of Birth: _____
(Please print)

3. Address: _____
Street City State Zip

4. Images/reports to be disclosed to: _____
Name of Person or Facility

Address: _____
Street City State Zip

5. Patient's Telephone #: _____

6. Imaging you are requesting.

Date: _____ Description: _____

Date: _____ Description: _____

Date: _____ Description: _____

7. The above information is disclosed for the following purpose(s):

❒ Medical Care ❒ Legal ❒ Insurance ❒ Personal

8. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the above information, to those persons and/or agencies named above. I further release South Shore Health and its employees from any legal liability arising from the disclosure of this information to such persons or agencies named above, provided the disclosure of this information is done substantially in accordance with applicable law. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced South Shore Health in writing, unless action based on it has already begun. I understand that this authorization will expire 90 days from the date of said authorization.

I, _____, authorize South Shore Health to release diagnostic images and reports which may contain statutorily protected health information including, mental health conditions, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with a disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV). I understand that information disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may be subject to federal or state law protecting its confidentiality.

9. _____
Signature of Patient or Authorized Representative

11. _____
Date

12. _____
Printed Name of Patient or Legal Representative

13. _____
Relationship to patient or authority to act for patient