



Patient Authorization for Release of Medical Records

Please mail or fax requests to: Image Library / Austin Radiological Association / 12554 Riata Vista Circle / Austin, TX 78727
Phone: 512.719.8230 Fax: 512.837.2105

Type of record requested Date of Request:
Radiograph (CD) Diagnostic Report Designated Record Set Billing Record

Patient Information
Patient Name:
DOB: SSN: MRN:
Daytime Phone: Name of Parent/Legal Guardian:

Exam Information
Date of Exam: Type of Exam:
ACC: For Multiple Exams, Date Range (from): (to):

Who is requesting release of Medical Records?
Patient Patient Representative Physician Hospital Freestanding Imaging Center Legal Representative
Other Name of Requestor:
Reason Requesting Medical Records: Continued Medical Care Part of patient's treatment team
Patient will hand carry records to physician office Other

Patient Signature - Authorization for Austin Radiological Association to Release Records documented on this form
Signature: Date:

Where is ARA to send requested Medical Records?
Mail Fax
Name:
Address: City/State/Zip
Phone Number: Fax Number:
Will records be picked up? Patient Patient Representative Courier Service Legal Representative
Patient Designee as noted below
I (patient name), grant access to pick up the medical records documented on this form to (name and relationship to patient).
Signature of patient: Date:

For internal use only:
Date Records Released: Verification of ID Completed Yes ARA initials
Who is picking up the records? ( Complete only if records are picked up )
Signature: Date:
Print Name: Relationship to patient:

In signing this form, I understand and accept full responsibility for the medical records (i.e. confidential information) I am about to receive. I relinquish Austin Radiological Association of any and all accountabilities concerning these medical records. I understand that I have the right, per HIPAA §164.508, to revoke this authorization in writing by sending written notice to: Attention: Privacy Officer, Austin Radiological Association, P.O. Box 4099, Austin, TX 78765. I understand that a revocation is not effective to the extent that Austin Radiological Association has relied on the authorization to disclose protected health information; and I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

THIS FORM IS NOT VALID 1 YEAR BEYOND DATE OF REQUEST. DATES AND SIGNATURES ARE REQUIRED.

We are allowed to charge you a reasonable fee to cover our costs for making copies of digital images and may charge for multiple copies of paper records.