DIAGNOSTIC IMAGING

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.