

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 ☐ Des	ignated Record Set
	<u></u>
Patient Information	
Patient Name:	
	MRN:
Daytime Phone: Name	of Parent/Legal Guardian:
Exam Information	
Date of Exam: Type of Exa	am: (to): (to):
ACC: For Multiple Exams, Da	ate Range (from): (to):
Who is representing release of Madical Passada	
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: Continue	ed Medical Care 🗌 Part of patient's treatment team
☐ Patient will hand carry records to physician offi	ce
<u>Patient Signature</u> - Authorization for Austin Radio	ological Association to Release Records documented on this form
Signatura	Dates
Signature:	Date:
Signature:	
Where is ARA to send requested Medical Record Mail Fax Name:	<u>s?</u>
Where is ARA to send requested Medical Record Mail Fax Name:	<u>s?</u>
Where is ARA to send requested Medical Record Mail Fax Name:	<u>s?</u>
Where is ARA to send requested Medical Record Mail Fax Name:	<u>s?</u>
Where is ARA to send requested Medical Record Mail Fax Name: Address: Phone Number: ()	<u>s?</u>
Where is ARA to send requested Medical Record Mail Fax Name: Address: Phone Number: () Will records be picked up? Patient Patient	City/State/Zip Fax Number ()
Where is ARA to send requested Medical Record Mail Fax Name: Address: Phone Number: () Will records be picked up? Patient Patient Patient Patient Designee as noted below	City/State/Zip Fax Number () Representative Courier Service Legal Representative
Where is ARA to send requested Medical Record ☐ Mail ☐ Fax Name:	City/State/Zip
Where is ARA to send requested Medical Record Mail Fax Name:	City/State/Zip
Where is ARA to send requested Medical Record ☐ Mail ☐ Fax Name:	City/State/Zip
Where is ARA to send requested Medical Record Mail Fax Name: Address: Phone Number: () Will records be picked up? Patient Patient Patient Patient Designee as noted below Signature of patient:	City/State/Zip
Where is ARA to send requested Medical Record Mail Fax Name:	
Where is ARA to send requested Medical Record Mail Fax Name:	City/State/Zip
Where is ARA to send requested Medical Record Mail Fax Name: Address: Phone Number: () Will records be picked up? Patient Patient Patient Designee as noted below I Signature of patient: For internal use only: Date Records Released: Verification Verifi	City/State/Zip
Where is ARA to send requested Medical Record Mail Fax Name: Address: Phone Number: () Will records be picked up? Patient Patient Patient Patient Designee as noted below Signature of patient: For internal use only: Date Records Released: Verifications Verificat	City/State/Zip

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.