PRINT SAVE AS RESET

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION - RADIOLOGY

When you complete and sign this form, health information about you will be released as you describe in the form. Please read each section carefully and complete the required sections before signing. We encourage you to request a copy of your records and review them before authorizing the release of the records to someone other than you. Please clearly and legibly print all information when completing this form and sign on the last page.

Submit completed and signed Authorization to Radiology Image Library by faxing to (650) 723-3995, emailing a pdf file to imagelibrary@stanfordhealthcare.org or mailing to the address below.

Patient's name: Last: _____ *First:* _____ *MI:* _____

Date of birth: _____ *Phone number:* _____ *Medical Record No:* _____

I authorize: ❑ **Stanford Health Care (SHC) - Radiology Image Library**
300 Pasteur Drive H-1329, Stanford, CA 94305
P: (650) 723-6717 F: (650) 723-3995

to release/disclose health information to:

_____

(Persons/Organizations authorized to receive the information)

_____

(Street address)

_____

(City, State and Zip Code)

The Purpose of this Release is for (check all that apply):

❑ Personal Use
❑ Legal Claim
❑ Other: _____
❑ Insurance
❑ Medical Care

Medical Record Number

Patient Name

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AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION RADIOLOGY

Information Requested:

❑ Radiology Images Only (CD) ❑ Radiology Images and Reports (CD & Paper)

Requests for only radiology reports must be submitted to the Release of Information office.

Date(s) of Treatment: ❑ From _____ To _____ ❑ All dates of service

Describe what you want released: _____

Delivery Preference: ❑ Mail ❑ Pick Up location _____ at _____ AM/PM

Expiration of Authorization:

This authorization will automatically expire (1) year from the date of execution unless a different end date is specified (insert date): _____

Your Privacy Rights

- You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment or insurance payment or eligibility for benefits.
- You may revoke this authorization at any time, but you must do so in writing and submit it to the following address: Stanford Health Care, 300 Pasteur Drive, MC6330, Stanford CA 94305. Your revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- You have a right to receive a copy of this authorization.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such redisclosure, in some cases, may not be protected by State and Federal law. Please note that if you wish to impose restrictions on the recipient's use of health information you must contact the recipient directly.

Written signature required (typed out signature not accepted).

_____ _____ _____

Signature** (Patient/Legal Designated Representative)* ***Date ***Time***

_____ _____

Print name ***Relationship to Patient***

There may be a fee to disclose your records.

Allow up to 14 days for your request to be processed.