CHA Cambridge Health Alliance

Internal Use Only
MRN _____

Authorization for the Release of Protected Health Information (Radiology Images)

Patient Information

Last Name _____ **First Name** _____ **MI** ____ **DOB** ___/___/_____

Home Street Address _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Home Telephone (____) _____-_____ **Alternate Telephone** (____) _____-_____

I do hereby authorize Cambridge Health Alliance (CHA), Department of Radiology, to release the following medical images including imaging reports to the following persons at the locations or facilities listed below, for the purposes described:

Purpose:

☐ Medical Care ☐ Insurance ☐ Legal ☐ Personal

☐ Other: _____

Information to be Released:

Exam: _____ Date Performed: _____

Exam: _____ Date Performed: _____

Exam: _____ Date Performed: _____

Other: _____

Release Information to:

Name/Facility: _____

Attention to: _____

Address: _____ City: _____

State: ____ ZIP: _____ Phone: (____) _____-_____ Fax: (____) _____-_____

I understand that:

- I may revoke my authorization at any time by submitting a written request to the Director of Radiology.
  Authorization may be withdrawn except for the following:
  - To the extent that action has been taken in reliance on this authorization.
  - If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by CHA.

I have read and understand the terms of this Authorization and I have had the opportunity to ask questions about obtaining, using and disclosing my health information as listed above. By my signature below, I hereby knowingly & voluntarily authorize Cambridge Health Alliance to obtain, use and/or disclose my radiology images in the manner described above.

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Signature of Patient/Signature of person authorized to sign for patient:
_____ Date_____ Time _____
Relationship to patient: ☐ Parent ☐ Legal Representative

Witness Signature (If telephone or verbal consent):
_____ Date _____ Time _____

☐ Yes ☐ No An interpreter was used in obtaining this consent