CHA Cambridge Health Alliance

Internal Use Only
MRN _____

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

Patient Name: Last _____ First _____ Middle _____ DOB __/__/____

Home Address: _____

City: _____State: _____ Zip: _____

Cell Phone: (_____) _____ Other Phone: (_____) _____

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:

❒ Medical Care ❒ Insurance ❒ Legal ❒ Personal ❒ Other:
_____

INFORMATION TO BE RELEASED
Exam: _____ Date Performed: _____
Exam: _____ Date Performed: _____
Exam: _____ Date Performed: _____
Other: _____

Release Information to:
❒ Patient ❒ Patient Representation: Name _____ ❒ Other
Name/Facility: _____
Attention to: _____ Phone: (___) - ___-____
Address: _____
City: _____ State: _____ Zip: _____

I understand that:

- I may withdraw 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  Authorization may be withdrawn except for the following: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 health information 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 _____

Provider/Authorized LIP Signature: _____ Date _____ Time _____

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

Please fax the form to any of the following numbers:

Cambridge Radiology/CHA Cambridge Hospital
1493 Cambridge Street Cambridge, MA 02139
Ph: 617-665-1831
Fax: 617-665-1649

Somerville Radiology/CHA Somerville Hospital
33 Tower Street Somerville, MA 02143
Ph: 617-591-4500
Fax: 617-591-4166

Everett Radiology/CHA Everett Hospital
103 Garland Street Everett, MA 02149
Ph: 617-381-7145
Fax: 617-394-7644