STAMFORD HEALTH
Healing. Reimagined.
Affiliate Columbia University College of Physicians and Surgeons
Member NewYork-Presbyterian Healthcare System
A Planetree Hospital

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# RADIOLOGY - AUTHORIZATION FOR RELEASE OF INFORMATION

## Phone (203) 276-7038 Fax (203) 276-7893

I, the undersigned patient or legal representative, hereby authorizes THE STAMFORD HEALTH SYSTEM to use or disclose health information.

**PLEASE PRINT CLEARLY AND COMPLETE THE FORM ON BOTH SIDES**

**Patient Information:**

**NAME:** ______________________________

**MEDICAL RECORD #:** ______________________________

**AKA / MAIDEN NAME:** ______________________________

**DATE OF BIRTH:** ______ / ______ / ______

**ADDRESS:** ______________________________

______________________________

**PHONE#:** ______________________________

**The purpose of this disclosure or use is for the following reason:**

☐ Medical ☐ Legal ☐ Disability ☐ Insurance

☐ At the request of the patient or legal representative

**The information may be disclosed to and used by the following:**

**NAME:** ______________________________

**ADDRESS:** ______________________________

______________________________

**PHONE #:** ______________________________

**FAX #:** ______________________________

**Format you would like to receive disclosed information:**

☐ Paper ☐ CD (Compact Disc) ☐ CD with Report

**Method of Delivery (For Paper or CD only):**

☐ Mail to address listed above ☐ Pick up On-Site

**ID Required:** ______________________________

**The date(s) of service and the type(s) of information to be used or disclosed is as follows:**

**Date(s) of treatment:** ______________________________

**Type of examination(s)**______________________________

☐ **Continuing of Care Document:** (Includes: Next of Kin, Primary Care Provider, Advance Directives, Problem List, Family History, Social History, Allergies/Adverse Reactions/Alerts, Medications, Immunizations, Procedures and Discharge Summary)

☐ Radiology Reports ☐ Radiology Films

☐ Other (please specify) ______________________________

______________________________

This authorization will be valid for a period of one year from the date below. I understand that I may cancel this authorization at any time by notifying the Radiology Department in writing, but if I do it will not have any effect on actions that the hospital took before it received the cancellation.

I understand that my treatment or continued treatment by The Stamford Health System is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it.

I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that I may inspect or copy the information to be used or disclosed.

The patient's parent or legal guardian must sign this authorization if the patient is a minor (under age 18) or has a legal guardian. Minors may sign their own authorizations for records relating to drug/alcohol abuse treatment, sexually transmitted diseases or HIV/AIDS related diagnoses, and in certain circumstances, Mental Health treatment records.

I understand that The Stamford Health System may receive compensation for copying and processing fees related to the use/disclosure of my health information under this authorization.

______________________________________________________________________________

Patient's Email Address

__________________________________________ ___________________________________

Signature of Patient | Today's Date

__________________________________________ ___________________________________

Signature of Authorized Representative | Witness

**If signed by the Authorized Representative, indicate your relationship to the patient below and provide a copy of the supporting documentation:**

☐Parent ☐Guardian ☐Conservator ☐Executor of Estate ☐Power of Attorney

☐Other (Please Specify) ____________________________________________________________

**OFFICE USE ONLY**

Requestor ID verified by: _________________ MRN: ___________ Date copies mailed: __________________
Employee Name

**A copy of this signed authorization form must be given to the patient or patient's representative.**

Created: 5/13