



Medical Records Request/Release

Patient Name: _____ Jacket #: _____ Date of Birth: _____

Phone: _____ other name(s) on prior studies: _____

REQUEST OUTSIDE IMAGES WITH REPORT TO BE SENT TO RADIOLOGY REGIONAL: ☐ All Breast Imaging & Reports

Images/Dates: _____

From Physician/Facility: _____

Address: _____ Fax: _____

Phone: _____ Email: _____

☐ **PowerShare** - share and exchange medical images (preferred method)

☐ **Send requested records in DICOM CD format to:**

Radiology Regional

Attn: Medical Records

3660 Broadway Ave. Fort Myers, FL 33901

Phone: (239) 275-3160 Fax: (239) 275-6455

*We do not accept encrypted CDs

***Please include this release with images sent**

☐ **RELEASE OF RADIOLOGY REGIONAL RECORDS TO OUTSIDE FACILITY** ☐ **IMAGES** ☐ **REPORTS**

☐ **POWERSHARE** ☐ **CD**

Images/Dates: _____

To Physician/Facility: _____

Address: _____ Fax: _____

Phone: _____ Email: _____

☐ **POWERSHARE for IMAGES to:** Email: _____, at patients request.

- ▶ I understand that I have the right to revoke this Authorization at any time in writing, except to the extent that Radiology Regional Center PA, has already acted in reliance on this Authorization. I can revoke this authorization by providing written revocation to: Radiology Regional Center PA Attn: Privacy Officer, 3660 Broadway Fort Myers, and Fl. 33901.
- ▶ I understand that failure to sign this authorization, Radiology Regional Center PA, may not refuse treatment, payment, enrollment, or eligibility of benefits to me.
- ▶ I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to applicable privacy laws.
- ▶ This Authorization shall be effective for two years or until I revoke it in writing.

****In lieu of patient signature, please process record request as CONTINUATION OF CARE****

Patient or Representative Signature

Printed Name

Date

*Must be parent, legal guardian and/or have written proof of Authorized Representative and a copy of this proof must be attached to this release/request.

Important:

This facsimile contains PRIVILEGED AND CONFIDENTIAL health/doctor/company information intended only for the use of the individual or entity to which it is addressed. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this facsimile in error, please notify us immediately by telephone.