Consulting Radiologists, Ltd.

CRL Women's Imaging

## AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

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|---|---|
| **PATIENT INFORMATION** | Name: _____ Date of Birth: _____<br>Address: _____ Day Phone: _____<br>City: _____ State: _____ Zip: _____<br>Email: _____ |
| **RELEASE MY MEDICAL RECORDS FROM** | ☐ CRL Imaging Southdale/Women's Imaging ☐ CRL Imaging Plymouth<br>☐ Other:<br>Name: _____<br>Address: _____ Day Phone: _____<br>City: _____ State: _____ Zip: _____ |
| **SEND MY MEDICAL RECORDS TO** | ☐ CRL Imaging Southdale/Women's Imaging,<br>6525 France Ave. S. Suite 110<br>Edina, MN 55435 P: 952-915-4320 F: 952-915-4338<br>☐ Other:<br>Name: _____ Attention to: _____<br>Address: _____ Day Phone: _____<br>City: _____ State: _____ Zip: _____<br>Fax Number: _____ |
| **INFORMATION TO BE RELEASED** | ☐ Images & Report(s) ☐ Report(s) Only<br>Date(s) or Date Range of Service:<br>☐ Bone Density ☐ Mammograms ☐ CT ☐ MRI ☐ Ultrasound<br>☐ X-Ray ☐ Other: _____ |
| **RELEASE METHOD/FORMAT** | Date information is needed: _____ (**Allow 48 Hours to Process Request**)<br>☐ Mail ☐ Pick-up ☐Email (Reports Only) ☐ Self ☐ Representative<br>☐Nuance PowerShare: Consulting Radiologists, Ltd |
| **PURPOSE OF RELEASE** | ☐ Continuing Care ☐ Transfer of Care ☐ Other _____<br>*Fees may be charged in accordance with MN statute 144.292 or Federal Rule 45C.F.R |

- This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____
- This authorization may be cancelled in writing at any time. A cancellation will not change releases that happen before the cancellation. To cancel a release, call or send a request to the 'Requested Release Form' address above.
- A photocopy/fax of this authorization will be treated the same as an original copy.
- Consulting Radiologists, Ltd. and its affiliates; CRL Imaging, CRL Women's Imaging cannot prevent re-disclosure of your information by the person or organization who receives your records under this authorization, and that information may not be covered by State or Federal privacy protections after it is released. By signing this authorization, you release Consulting Radiologists, Ltd. and its affiliates; CRL Imaging, CRL Women's Imaging from any and all liability resulting from re-disclosure by the recipient.
- Consulting Radiologists, Ltd. and its affiliates; CRL Imaging, CRL Women's Imaging will not condition treatment on whether you sign this form.
- Your signature indicates that you have read and understand this form and authorize release of your information as described above.

_____

Patient/Legal Guardian Signature Date Authority to Act on Behalf of Patient

**Office Use Only**

Received Date: _____ Reviewed Date: _____ ☐ Identity Verified Date submitted to patient: _____