RADIOLOGY MEDICAL INFORMATION RELEASE AUTHORIZATION
(Authorization for St. Joseph Hospital of Orange to Release Radiology Films)

Patient Name: _____

Patient Date of Birth: _____

Medical Record # (if known): _____

Information to be released to: _____

Information released: _____ Date out: _____

Transport Via: _____

Reason for Release and Limited to: _____ MD consultation _____ Other

- *I understand that St. Joseph hospital has released original/copy radiology films and I release St. Joseph Hospital from all responsibility for and liability that may arise as a result of this release of original/copy materials. .*
- *I understand that I may revoke this consent at any time in writing except to the extent that the information has already been released.*
- *I understand that there is the potential that the information released by my authorization may be subject to re-disclosure by the recipient of the information.*
- *I understand that St. Joseph Hospital may not condition treatment or payment on my signature on this authorization except in the case of research-related treatment.*
- *I understand this Authorization will expire immediately after the completion of this release.*

_____ _____
Patient/Authorized Representative Date

_____ _____
Printed Name of Patient or Authorized Representative Relationship to Patient

_____ _____
Prepared By/Date/Time Released By/Date

Additional Comments: _____