

Image Service Center

55 Fruit Street Blake Sub-basement 0029A Boston, MA 02114 T (617) 726-1798 F (617) 724-0264

AUTHORIZATION FOR RELEASE OF MEDICAL IMAGES

PATIENT NAME:	PATIENT DATE OF BIRTH:
PATIENT MEDICAL RECORD #:	PREFERRED PHONE #:
PATIENT ADDRESS:	
I understand that my medical image reports may conta by signing this consent I explicitly consent to such info	in sensitive protected health information such as HIV, and rmation being released if it is contained in the report.
I hereby authorize, to release me	dical images along with the reports as indicated below:
PURPOSE:	SEND BY:
☐ Medical Care	☐ Mail (provide mailing address)
☐ Personal	
☐ Legal	☐ Electronic Portal
☐ School	
□ Other (specify)	☐ Pick up
TO:	SEND:
Name:	Exam Date(s):
Address:	Exam Type(s):
 its confidentiality at Mass General Brigham may or mather recipient This authorization is voluntary My treatment, payment, health plan enrollment, or eligiting and the payment and the payment and the payment originally submitted it, except: if Mass General Brigham has already processed the it will not be retrieved) if I signed this authorization as a condition of obtain a right to contest a claim under the policy or the policy or the payment authorization will automatically expire 6 months My questions about this authorization form have been 	from the date signed unless otherwise specified:
Signature Requirement: When patient is a minor, or is not guardian, or other legal representative is required.	competent to give consent, the signature of a parent,
Signature of Patient Printed Nam	ne Date
Signature of Parent (if patient is under 18); Printed Nam	ne of Parent/Legal Surrogate Date

or Legal Surrogate (circle one)