Advanced Radiology

INFORMATION RELEASE AUTHORIZATION

Patient Name _____ Date of Birth _____

Telephone _____

Street Address _____

City _____ State _____ Zip _____

I hereby authorize the following information to be released to Advanced Radiology Consultants and its affiliated entities from:

Individual / Institution: _____

Street Address _____

City _____ State _____ Zip _____

Date(s) of Exam _____

Information to be released:

○ Laboratory Reports ○ Imaging Reports ○ Imaging Studies (preferably by CD)
○ Pathology Reports ○ Operative Reports

Please forward requested information to:

☐ **Fairfield**
1055 Post Road, Fairfield, CT 06824
Fax: 203.356.9836

☐ **Orange**
297 Boston Post Road, Orange, CT 06477
Fax: 203.891.1693

☐ **Shelton**
4 Corporate Drive, Suite 182
Shelton, CT 06484
Fax: 203.926.6954

☐ **Stamford**
1259 East Main Street, Stamford, CT 06902
Fax: 203.356.9836

☐ **Stratford**
2876 Main Street, Stratford, CT 06614
Fax: 203.375.9452

☐ **Trumbull**
15 Corporate Drive, Trumbull, CT 06611
Fax: 203.459.0116

☐ **Wilton**
30 Danbury Road, Wilton, CT 06897
Fax: 203.665.9730

As part of our ongoing Quality Assurance Program, we make every effort to correlate biopsy results. Do we have your permission to obtain biopsy results from your doctor or hospital?

○ Yes ○ No

Date on which authorization will expire: _____ / _____ / _____

If blank, authorization will expire 12 months from date of signature

I hereby authorize that the records described above may be released to or recieved by Advanced Radiology Consultants and its affiliated entities. I understand that I am not required to sign this authorization as a condition of treatment, payment, enrollment, or eligibility for benefits. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on the authorization. The revocation letter should be sent to Advanced Radiology Consultants, 3 Enterprise Drive, Suite 220, Shelton, CT, 06484. By signing below, I acknowledge that I have read and understand this authorization agreement.

_____ _____

Signature of Patient or Patient's Authorized Representative **Date**

_____ _____

Authorized Representative (Please print name) **Relationship to Patient**

If signed by the patient's representative, please specify the representative's relationship to the patient and authority to act on their behalf. If the patient is a minor (less than 18 years of age) or has a legal guardian, in most cases this authorization must be signed by the patient's parent or legal guardian. If the hospital/provider determines that the minor's consent is necessary to release the requested records, the hospital/provider will contact the minor to obtain his/her authorization.