HealthAlliance Hospital
A Member of UMass Memorial Health Care
60 Hospital Road
Leominster, MA 01453-8004

RL0004

RL0004 / Correspondence

MR#:_____

Please Request MRI Films and Reports from "Shields MRI" 1-508-897-1529

Authorization for the Disclosure of Personal Health Information

I hereby authorize HealthAlliance Hospitals, their employees, and/or agents, to release information from the record of:

Patient Name: First: *Please Print*	**MI:**	**Last:** **Suffix:** (Sr. Jr. I, II, etc)	Sex: ❒ M ❒ F Check one::
Street:			Floor/Apt#:
City:	State:		Zip Code:
Phone #:	Date of Birth:		
Please Release To: ❒ **Self** ❒ **Physician Continuum of Care**		❒ **Insurance Co and/or Attorney/Lawyer Send this request to the HIS Department FAX 978-466-2789**	
Release to Name:			
Street:	PO Box/Suite #:		
City:	State:		Zip Code:
Phone #:	Fax #:		

I would like to request Radiology Film(s)/CD/Report(s)

Please allow 24 hours (Business Days: M-F) to process your request. Please check all that apply below:

☒ **Radiology Film(s)/CD(s)/Report(s)** Date(s) of Service: _____

Date Needed: _____ Picture(s) of: _____

The Reason for Request is: (check one)

❒ Continuing Medical TX ❒ Self- Personal Use

If the release is for *any other reason* please complete this form and send it to:

HealthAlliance Medical Records Department Fax#: 978-466-2789

Requested Means of Delivery:

Picture ID Required when picking up Radiology Film(s)/CD(s)/Report(s)

PICK UP ONLY: ❒ Self ❒ Other * **(indicate who/relationship below)**

Please Specify Which Location

Radiology Film(s)/CD(s)/Report(s) - Pick Up in Radiology Department ❒ Leominster or ❒ Burbank Campuses

Please call the Radiology Department (978-466-2689), *prior to your arrival*, to ensure the requested items are ready when you Arrive, at the appropriate Campus.

***If someone other than the patient will pick up the Film/CD/Report please provide their name and relationship below:**

Name:_____**Relationship to Patient:**_____

Patients….Please Continue On Reverse Side

Radiology Staff ONLY

Date Sent / Picked Up: _____

Number of Pages Sent: _____

Processor's Initials: _____

Patient Name: First: _____ MI: _____Last:_____

I understand the following:

- This authorization is voluntary.
- Per the Notice of Information, I have the right to inspect or request copies of my medical records. Arrangements must be made to inspect my medical record on-site; please contact the Health Information Services Department at 978-466-2834.
- A fee for photocopies of my medical record may apply; per Massachusetts General Law; Chapter 111, Section 70.
- Any disclosure carries the potential for unauthorized re-disclosure. I release HealthAlliance from any legal liability that may arise from the disclosure or re-disclosure of this information.
- I have the right to revoke the authorization at any time by presenting a written request to the Health Information Services Department (Medical Records) at the address below. Revocation will not apply to information that has already been released in response to this authorization. Revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Expiration of Authorization: Unless otherwise revoked in writing, this authorization will expire on the following date, event or condition: If I fail to specify an expiration date, event or condition, this authorization shall be valid for not more than ninety (90) days from the date of the signature below, except when Federal and/or State regulations specify otherwise.

Radiology Films/CD's/Reports may be picked up in the Radiology Department.
Film(s)/CD(s)/Report(s) may be transported to the Burbank Campus Radiology Department for patient convenience.
Please indicate your pickup location preference on the reverse side of this form.

Original films released MUST be returned to HealthAlliance.
By signing this form, you are accepting responsibility for the return of all original films released to you.

I have completed all sections of this form. I have read and understand the above statements and authorize the disclosure of the information requested on the reverse side of this form.

_____	_____	_____
Signature of Patient / Parent / Legal Guardian	**Date**	**Relationship to Patient**

Please Mail	**HealthAlliance Hospital** **60 Hospital Road** **Attn: Radiology Image Library** **Leominster, MA 01453**
OR	
FAX Request to:	**978-466-4789** **Attn: Radiology Image Library** **Leominster Campus**
Questions?	**Call Radiology Image Library - Phone #: 978-466-2689**