

RELEASE OF MEDICAL INFORMATION

DATE: _____

INFORMATION REQUESTED BY:

Provider _____ Patient or patient representative

Patient Full Name: _____ Date of Birth: _____

Previous Name: _____ Phone: (____) _____

Send to:

Physician's Name or Organization (please print): _____

Patient Pick Up Date: _____ AM / PM TO (Doctor/Facility): _____

Courier TO: _____

Mail to: _____

Patient will be charged for sending records/films via certified registered mail if they are not picking them up and delivering them to the physician's office.

Reports from Exam Date(s): _____

Films: CD MRI CT Mammo US XR Body Part: _____

Exam Date(s) (mo/yr): _____

Notes: _____

MEDWISE STAFF MEMBER COMPLETING FORM: _____

I understand that MedWise radiographic films are the property of MedWise, PC and are a legal record held by the radiology department. By requesting to personally remove films from MedWise, I assume full responsibility for the custody of films.

Identification will be required to pick up patient records/films

Signed: _____

- If not signed by the patient, please indicate. Relationship:
- parent or guardian of minor patient
 - guardian or conservator of an incompetent patient
 - beneficiary or personal representative of deceased patient
 - spouse
 - other relative (specify) _____

Print Name: _____
First Middle Last

ID checked: _____ (MedWise employee)

Personally given to patient or patient's personal representative on Date: _____

Permanent Release for Mammography Films on Back of Form

I understand that MedWise mammographic films are the property of MedWise, PC and are a legal record held by the radiology department. By requesting to personally remove films from MedWise with the intent to keep these films in my possession on a permanent basis, I assume full responsibility for the custody of films and release MedWise from any future responsibility related to providing the films to requesting parties or agencies.

Identification will be required to pick up patient records/films

Signed: _____

If not signed by the patient, please indicate. Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient
- spouse
- other relative (specify) _____

Print Name: _____
 First Middle Last

ID checked: _____ (MedWise employee)

Personally given to patient or patient's personal representative on Date: _____

DECEASED PATIENT MEDICAL RECORDS RELEASE

I have provided a copy of my identification and certify that I am the above patient's nearest living relative, (circle one) spouse, child, parent, grandchild, other blood relative (please specify) _____ or have authorization by a Power of Attorney to request release of this patient's medical records.

Printed Name: _____ Signature: _____ Date: _____

For MedWise Office Use Only

Reports / Films (circle one or both) were: _____ Mailed on Date: _____

_____ Faxed on Date: _____ Sent by Courier on Date: _____

Entered: _____ Computer _____ On Jacket _____ On Sleeve _____ On Courier log (if applicable)

Employee Initials: _____

Films returned on (date): _____ Employee Initials: _____

PLACE THIS ORIGINAL REQUEST FORM IN THE PATIENT'S CHART.