North Fork Radiology, P.C.

1333 Roanoke Avenue ● Riverhead, NY 11901 ● 631-727-2755

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

REQUESTED PICK-UP DATE: _____ TIME: _____

PATIENT'S NAME: _____

DOB: _____ PHONE:#:_____

TODAY'S DATE: _____TIME:_____ COMPLETED BY: _____

TYPE of MEDIA / EXAM REQUESTED

□ **CD** _____

□ **FILM COPIES** _____

□ **FILM ORIGINALS **** _____

Records prepared by: _____

Patient Authorization

I authorize North Fork Radiology to release my medical imaging records including my radiographs, professional interpretations, reports, and other medical information to the "Authorized Person" whose name appears below. I understand that this authorization will not transfer to another person.

To: Me ____, My spouse ____, My parent _____, Legal guardian_____, My child _____,

Name and relation of person other than me: _____

Patient signature: _____ Date:_____

Authorized recipient: _____ Date:_____

Sign-out witness: _____