Saint Clare's Health
Around the corner. Ahead of the curve.

MRN # _____

DIAGNOSTIC IMAGING RELEASE OF HEALTH INFORMATION

PATIENT SECTION (Please print clearly)

Last Name_____ **First Name**_____ **DOB**_____

Street Address_____

City_____ **State**_____ **Zip**_____ **Phone #**_____

Purpose of requested Health Information: ❒**Patient request** ❒**Other**_____

❒**Mail to patient (home address only via USPS)**

❒ **Patient pick up**

❒ **Picking up for patient **requires written/signed permission from patient/ID of person picking up Health Information****

❒ **Parent picking up for minor child **Legal age of consent is 14. We reserve the right to deny access to sensitive health Information.**

❒**Mail to physician/medical facility – provide name & complete mailing address**_____

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HEALTH INFORMATION TO BE RELEASED

❒**BONE DENSITY** ❒ **CT SCAN** ❒**MAMMOGRAPHY** ❒**MRI** ❒**NUCLEAR MEDICINE** ❒**PET** ❒**ULTRASOUND** ❒ **XRAY**

❒**CD/Image(s)**

❒**Report(s)**

SIGNATURES

Patient Signature_____ **Date**_____

IF NOT PATIENT: Name (please print)_____ **Signature**_____

FOR OFFICE USE ONLY

❒ **Note from patient** (if picked up by someone other than pt) **received/scanned** ❒**ID Verified – type of ID**_____

Employee Initials _____ By signing my initials, I certify that the patient name, DOB & study image(s) have been verified prior to distribution.

Date_____ **Location:** ❒ **DE** ❒ **DO** ❒ **PC** ❒ **WHC**

Comments_____