AUTHORIZATION TO RELEASE RADIOLOGY IMAGES

WHITMAN HOSPITAL RADIOLOGY DEPARTMENT
1200 West Fairview Street, Colfax, WA 99111
Telephone: (509) 397-3435
Fax: (509) 397-5780

Patient's Name: _____

Date of Birth: _____

Medical Record Number: _____

This is to authorize that medical information regarding the above identified person be forwarded by a Whitman Hospital and Medical Center employee.

From:

WHITMAN HOSPITAL AND MEDICAL CENTER
1200 West Fairview Street
Colfax, WA 99111

To:

_____
Physician/Individual/Institution Requesting Medical Data

_____
Street Address

_____
City State Zip

_____
Fax Number Phone Number

PURPOSE OR NEED FOR DATA:

- ☐ Continuing Care
- ☐ Other _____

DATES REQUESTED: Dates of Treatment: _____

- ☐ Images on CD

RIGHTS OF THE PATIENT

- The information listed here above is to be released for the stated purpose only. Any other use is forbidden.
- This authorization is voluntary and I may refuse to sign this form. I will not be refused treatment if I refuse to sign this form.
- This authorization is valid for a period of 90 days. I understand that I may also revoke authorization at any time by contacting Health Information Management at Whitman Hospital and Medical Center. My revocation must be in writing. However, the hospital is not responsible for actions already taken based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law.

SIGNATURE

Signature: _____ Date: _____

Relationship to Patient: _____ IDENTIFICATION CHECK: ☐YES ☐NO

Released by WHMC Staff: _____ _____ _____
Date Initials Chart #