



MEDICAL RECORD RELEASE FORM
of PATIENT HEALTH INFORMATION (PHI)

Phone: (813) 875-7424; Fax: (813) 872-2799 (Attn: CMR Manager)

Date of Request: Time: Date Required: Pick Up Site: (if applicable)

Patient Name: DOB: Phone #:

The undersigned requests and authorizes Tower Radiology to provide personal health information to:

Name (Medical Facility):

Address:

City, State, Zip:

The method I would like my personal health information provided is:

Mail record to above medical facility I, or an authorized person, will pick up health information (proper ID and letter required)*

Mail Outside Facility's Medical Records to Tower Radiology for Comparison: Tower Radiology, Central Medical Records Dept., Attn: Luana Simpkins/Bob Siwiecki, 2728 University Square Dr., Tampa, FL 33612

This information, for which I am authorizing disclosure, will be used for the following purpose(s):

Continuing Medical Care Personal Use Information for Insurance Company
Information for Attorney Comparison Other:

Media Requested: CD Film Report

Date of Exam: Type of Exam:

I, (Patient, Parent or Guardian), hereby voluntarily authorize the disclosure of information from my health record. This authorization will expire one year from the date of this request. However, each time new records are requested, a new request is required. This authorization is not valid if not filled out completely. A copy of this consent is as valid as the original.

I understand that the information outlined in this release will be disclosed according to the instructions of this release within (5) business days of Tower Imaging, Inc. having received this release authorization. I understand that I am free to revoke this release authorization at any time by notification in writing to Tower Imaging, Inc., Attn: HIPAA Privacy Officer, 2700 University Square Dr., Tampa, FL 33612.

FILM OR CD'S ONLY

The digital film or CD is given to the patient to keep. PLEASE DO NOT RETURN THEM. If you do return them, they will be destroyed. If the patient wants another copy of these films, even if they were returned to us, the patient will be responsible for paying for a new set to be printed. CD's ARE FREE.

Signature: Date: (Patient, Parent or Guardian)

FOR OFFICE USE ONLY

PICKING UP PROTECTED HEALTH INFORMATION REQUIRES IDENTIFICATION

PID: Form of ID Provided:* ID VERIFIED & SCANNED: YES NO

Employee signature:

Employee Requesting Images: Films/CD created and QC'd by:

REVOCATION:

This authorization was revoked on this day of, 201. Revocation letter/document must be attached.

SCAN THIS FORM IN THE MASTER FOLDER UNDER EVERY EXAM RELEASED.

*Anyone picking up PHI, must have a valid ID. The person authorized to retrieve PHI on behalf of the patient must have a signed letter from the patient before records can be released.