Boca Raton Regional Hospital
BAPTIST HEALTH SOUTH FLORIDA

Confidential Release of Radiology Records

(561) 955-5683

Patient Name: ______________________ DOB: ______________

Last 4 digits of Social Security#: ______________________ MR#: ______________

Patient's Phone #: ______________________ Email: ______________

I authorize release of my medical records to the party listed below by Boca Raton Regional Hospital:

Release Records TO:
Name/Facility: ______________________
Address: ______________________

____

Phone: ______________________
Fax: ______________________
Email: ______________________

I authorize the party listed below to release my records to Boca Raton Regional Hospital:

Reqesting Records FROM:
Name/Facility: ______________________
Address: ______________________

____

Send To: Boca Raton Regional Hospital
690 Meadows Road, Boca Raton, FL 33486
Fax: (561) 955- ________ Email: Imaging@BRRH.com

Which format would you prefer?

☐ CD (subject to processing fee $6.50 per disc plus appropriate postage/tax)

☐ Email (No Charge): ______________________
(Please print clearly)

Please indicate which tests you are requesting to be released and the dates:

Exam	Date(s) of Service	Exam	Date(s) of Service
☐ CT	________	☐ Mammogram(CESM	________
☐ MRI	________	☐ Breast Ultrasound	________
☐ Nuclear Medicine	________	☐ Bone Density	________
☐ Ultrasound	________	☐ Breast Biopsy	________
		☐ (Include pathology/histology)	
☐ X-Ray	________	☐ Other	
☐ Interventional	________	________	________
☐ (Include pathology/histology)			

STAFF ONLY for EMAIL RELEASES: Completed by ______________ on ______________
Employee # Date/Time

For the purpose of ______________________ Explanation Date of this Authorization: One Year

To be completed by the patient or personal representative

I hereby authorize the use or disclosure of my protected health information as described above.
I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.
I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.
I understand that I have a right to revoke this authorization by sending written notification to: Boca Raton Regional Hospital. Attn: HIM\800 Meadows Road, Boca Raton, FL 33486
Any revocation will not affect disclosures made prior to Boca Raton Regional Hospital's receipt or knowledge of the revocation.

I understand that I have a right to inspect and receive a copy of the information described on this form.

__________ __________ ______________________
Date Time Signature of patient or patient's representative/Power of Attorney

______________________ ______________________
Relationship to the patient Printed name of patient's representative/Power of Attorney

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