Southwestern Vermont Medical Center
Department of Imaging
100 Hospital Drive
Bennington, VT 05201
Telephone # : 802-447-5111

AUTHORIZATION FOR RELEASE OF RADIOLOGY FILMS/CD

Patient Name:	**Birth Date:**
Address:	**Telephone No.:**

☐ I hereby authorize the above-referenced entity to release my films indicated below to the following recipient of my continued care: or

☐ I hereby authorize the above-referenced entity to release my films indicated below directly to me so that I may hand-deliver them to the following recipient for purposes of my continued care:

Recipient Name:	**Telephone No.:**
Address:	

CD/Films Needed:

☐ Radiology (XRAY) ☐ Ultrasound (Sonogram) ☐ CT Scan

☐ Magnetic Resonance Imaging (MRI) ☐ Nuclear Medicine ☐ Mammography Films

☐ PET/CT ☐ Other: _____ ☐ **Include All Reports**

Dates of Service Needed:

☐ All ☐ Most Recent Exam (Date: ___/___/___) ☐ From: __/__/__ To:__/__/__

I understand that this Authorization will remain in effect for one (1) year, but I may revoke it at any time in writing. I further understand that any such revocation will not apply to any films already released under this Authorization. I understand that I am under no obligation to sign this Authorization, and that my ability to obtain treatment from Southwestern Vermont Medical Center will not depend in any way on whether I sign this Authorization. I understand that I have a right to receive a copy of this Authorization.

I understand that state and federal law may prohibit the Recipient from re-disclosing films provided pursuant to this Authorization, but that neither Southwestern Vermont Medical Center nor the above-referenced entity has any control over the Recipient and cannot therefore guarantee that the Recipient will not re-disclose such films. I understand that these are originals and may not be replaceable and I hereby release Southwestern Vermont Medical Center and the above-referenced entity from any and all liability or consequences related to (i) their reliance upon this Authorization or (ii) the release of films pursuant to this Authorization, including, but not limited to, the unavailability of, loss of or damage to such films once they have left the above-referenced entity's premises. I will request the return of these films to the above-referenced entity after the Recipient's need for them ceases.

If the above-referenced entity agrees to my request that it mail the films directly to the Recipient, I understand that the above-referenced entity may charge me a reasonable, cost-based fee for postage and I agree to pre-pay such amount.

By signing below, I authorize the entity checked above to release films as described above.

_____ _____ _____
Signature of Patient Date Time

If (i) the patient is a minor, the patient's guardian should consent by signing below, or (ii) if the patient is an adult but unable to consent for himself or herself, then the patient's guardian, legal representative, attorney-in-fact-, surrogate or proxy should consent on the patient's behalf by signing below:

_____ _____
Signature of Representative Telephone No.

_____ _____
Name of Representative Relationship to Patient

Date Mailed:	**Picked up By:** ☐ Patient on _____ or ☐ Recipient (or Recipient's Representative)

Employee Releasing Film: _____ _____
Print Name Signature