INOVA

1ROI

* All items with an asterisk are MANDATORY fields.

A

* Patient Name _____ Medical Record Number _____

* Patient Date of Birth _____ * Contact Phone Number _____

Contact Email _____

* Patient Address _____
Street Address City State Zip Code

B * **I authorize Inova to** (check one):

☐ **Release** the information indicated to:
☐ **Request** the information indicated from:

_____
Name of person or entity to receive or disclose information

_____
Street Address City State Zip Code

Phone# _____ Fax# _____ Email _____

C * **Information to be Released/Disclosed:**

☐ Radiology Images
☐ Radiology Reports
} **SPECIFY ▶**

Exam Date	Modality (CT, MRI, Neuro, Nuc Med, PET, Ultrasound, X-Ray)	Type of Exam (Head, Chest, etc.)

D * **Purpose** (check all that apply):

☐ Medical Follow-Up
☐ Other _____

E * **Provide Record by Means of** (check one):

☐ Image Sharing via Email ☐ CD – Pick-up ☐ CD – Mail – Regular

F I understand that:

- If the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.
- Written notification is necessary to cancel this authorization. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.
- This disclosure release may include sensitive information in my records that do not require separate authorization based on federal or state regulations.
- Treatment will still be provided to me if I do not sign this form.
- This authorization will expire six (6) months after the date signed.

_____ _____
* **Patient or Authorized Representative** (signature) * Date/Time (Authorization will expire six months after date signed)

_____ _____ ☐ Self
* **Patient or Authorized Representative** (print name) * Relationship to Patient (specify, or check box if "self")

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

Radiology Staff Use Only		
	Date Received: _____	Date Order Completed: _____
	Time Received: _____	Time Order Completed: _____
	Staff (print name): _____	Staff (print name): _____

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ☐ Male ☐ Female

Inova
Authorization to Request/Disclose Protected Health Information – Radiology Imaging

CAT # 21040DT / R060222 • PADS OF 100