INOVA

* 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