AUTHORIZATION FOR THE RELEASE OF RADIOLOGY IMAGES

Name:_____ SS#:_____

CCF#:_____ Date of Birth: _____ / _____ / _____

Telephone #:_____ Current Address:

Fax #:_____ Street:_____

Reason for Disclosure: Continuity of care City:_____ State:_____ Zip:_____

_____
(Reason for disclosure must be completed prior to processing.)

Past Dates of Treatment:_____

Release Radiology Images/Reports to: Name of Recipient: Dr Aaron Boster, The Boster Center for Multiple Sclerosis

Street: 8000 Ravines Edge Road, Suite 200

City: Columbus State: Ohio Zip: 43235

I hereby authorize to release the health information indicated below that is contained in my Radiology image records to the Recipient named above.

X	Radiology Images	X	Radiology Reports
	Mammography Films		Mammography Reports

This consent is subject to revocation at any time except to the extent the action has been taken thereon. **This authorization and consent will expire in one year from the date of authorization written below.**

I understand that the Recipient of my health information may be charged for the service of releasing my Radiology images.

Your health care (or payment for care) will not be affected by whether or not you sign this authorization. Once your health care information is released, redisclosure of your health care information by the Recipient may no longer be protected by law.

_____ / _____ _____ / _____ / _____
*Signature of Patient/Legal Guardian*** *Printed Name* *Date Signed*

_____
Relationship if not Patient

***If other than patient's signature, a copy of legal papers verifying authority (e.g., Power of Attorney or Death Certificate) **MUST** accompany the authorization when presented. Exception: parent is signing for patient under age 18.*