

# NCH Imaging

AUTHORIZATION FOR RELEASE OF RECORDS FROM ANOTHER FACILITY

\*\*\*This form needs to be emailed to Medicalrecordsxray@nchmd.org\*\*\*

## 1. PATIENT INFORMATION

Patient Name & Alias Name			
Street Address	City	State	Zip
Date of Birth (MM/DD/YYYY)	**Phone Number Required		

## 2. I AUTHORIZE RELEASE FROM:

\_\_\_\_\_

Name of Healthcare Provider

\_\_\_\_\_

Street Address

\_\_\_\_\_

City State Zip

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## 3. I AUTHORIZE DISCLOSURE TO:

NCHI Medical Records Department

1715 Medical Blvd, Bldg B

Naples, FL 34110

Phone (239) 624-6660

Fax (239) 624-6661

**4 PURPOSE OF DISCLOSURE:** The purpose of this disclosure is for continuation of care/transferring care.

## 5. TYPE OF MEDIA OR EXAM TO BE RELEASED:

**DATE OF SERVICE:** \_\_\_\_\_

CD/DVD

REPORT(s)

I understand that this Authorization is effective for a period of one (1) year from the date of signature, unless otherwise specified. I understand that I have the right to revoke this Authorization at any time by sending a written request to NCH Imaging Centers, except to the extent that action has already been taken. I understand that NCH Imaging Centers cannot require me to sign this Authorization as a condition for treatment. I understand that it is possible that re-disclosure of records may occur and that NCH Imaging Centers and its staff/employees have no responsibility or liability as a result of re-disclosure. I am entitled to a copy of this completed Authorization.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Legal Representative

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date