

NCH Imaging

AUTHORIZATION FOR RELEASE

This authorizes NCH to obtain your images from another medical facility

This form should be emailed to Medicalrecordsxray@nchmd.org

1. PATIENT INFORMATION

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

2. I AUTHORIZE RELEASE FROM:

Name of Healthcare Provider

Street Address

City

State

Zip

3. I AUTHORIZE DISCLOSURE TO:

NCHI Medical Records Department

1715 Medical Blvd, Bldg B

Naples, FL 34110

(239)624-6660

Attn: _____

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

FILM COPIES

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