

Authorization for Release of Radiology Images

Yale Medicine

Yale
NewHaven
Health

Patient Legal Name: _____
(Last) (First) M.I. Preferred Name (Maiden/Other Name)

Date of Birth: _____ **Phone:** _____ **Email:** _____

Address: _____
Street City State Zip Code

This information is to be used for purpose of: Personal use Continuing care Legal Disability Workers Comp
 Insurance Eligibility/Benefits Social Security Claim Veterans Benefits Other _____

Release radiology images to:

Name: _____ Phone: _____
Address: _____
Street City State Zip Code

Requested Delivery Method:

Electronic
Facility Ambra Link or Share Code (if available): _____
 Physical Copy/CD
 U.S Mail
 Pick Up/Hand Carry
 FedEx Account Number: _____

Location of Services: (Check all that apply)

Bridgeport Hospital Greenwich Hospital Lawrence & Memorial Hospital Westerly Hospital
 Yale New Haven Hospital Yale New Haven Urgent Care (formerly Physician One) Location: _____

Radiology Exams Requested:

Types of Radiology Exams/Modalities

_____ XR CT MRI US Mammo Other: _____
Date/Date Range

_____ XR CT MRI US Mammo Other: _____
Date/Date Range

_____ XR CT MRI US Mammo Other: _____
Date/Date Range

_____ XR CT MRI US Mammo Other: _____
Date/Date Range

_____ XR CT MRI US Mammo Other: _____
Date/Date Range

_____ XR CT MRI US Mammo Other: _____
Date/Date Range



SENSITIVE INFORMATION: I understand that the records I have selected to be released may contain information about treatment and testing regarding genetics, behavioral health, sexually transmitted disease, HIV/AIDS, reproductive health, gender affirming care, or testing/history of drug or alcohol use. By signing this authorization, I agree to the release of this information. I have the right to have my medical records released directly to me so that I can review and inspect the information. This includes reviewing the records for sensitive information I do not wish to be disclosed to a third party.

I understand that:

- This authorization is valid for one year from the date below. I understand that after I have signed this form, I may change my mind and cancel (revoke) this authorization at any time by contacting in writing YNHHS Radiology and Biomedical Imaging Department. Cancellation of the authorization will not apply to information that has already been released based on this authorization.
- The information disclosed in response to this authorization may be subject to re-disclosure by recipient, and will no longer be protected under the terms of this authorization or by federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
- That this authorization is voluntary and my treatment by YNHHS/Yale Medicine is in no way conditioned on whether or not I sign this authorization and that I may refuse to sign it. If I do not sign this form, payment for this care will only be affected if my health care insurer is requesting this information and is permitted to require this authorization.
- On request, I may review or have copied the information described on this form if I ask for it. There may be a charge for copies in accordance with Connecticut law.
- The parent or legal guardian must sign this authorization if the patient is a minor (under age 18) except where the records relate to treatment(s) which is protected under state law, in which case the minor must consent to release of the protected information. Signature of a minor age 13 or older is required for release of records related to HIV/AIDS, substance use (alcohol/drug treatment), pregnancy and pregnancy prevention, and/or sexually transmitted disease. Signature of a minor age 16 or older is required for release of behavioral health records.

Return completed authorization by mail, fax, or email as designated below.

Mail: 20 York Street
Attn: Film Library, NP2-206
New Haven, CT 06510
Fax: 203-688-8812
Email: radpatientrequest@ynhh.org
Questions? Call 203-688-6054

Printed Name: _____

Date: _____

Signature of Patient or Authorized Representative

***must provide proof of authority (except parent of a minor)*

Please check relationship to patient

- Self Parent Legal Guardian Executor/Administrator of Estate Healthcare Representative Conservator
 Other Authorized Legal Representative _____ (indicate)

Printed Name of Minor (when applicable)***

Signature of Minor (when applicable)***

Date