MH R&M MURRAY HILL
RADIOLOGY AND MAMMOGRAPHY
650 First Avenue, New York, NY 10016 · 212-686-4440 · Fax: 212-683-3092

Medical Records Release / Request Form

By completing this form, you are helping us by providing access to your prior medical records to compare with your new exam. If you do not remember all of the details of your prior exam, our staff will try to assist you in locating those records. Providing comparison images is extremely helpful to the radiologist during the interpretation of your new exam and sometimes eliminates the need for additional imaging.

PATIENT INFORMATION

Patient Name:		Date of Birth:	
Address:		Home Phone #:	
City/ State/ ZIP		Work #:	
Email:		Cell Phone #	

TYPE OF MEDICAL RECORD REQUESTED - Check all that apply and specify dates or date range requested.

❑ Mammogram	❑ Sonogram	❑ MRI	❑ Bone Densitometry	❑ Other

Our standard is to supply your digital images on CD. Please notify us if your doctor requests these images on film, **instead** of disk. Your record request may take 10 business days to complete, unless otherwise arranged. The process of printing your records **will not** begin until written authorization is received.

PURPOSE OF MEDICAL RECORD REQUEST - Check all that apply

Are you leaving Murray Hill Radiology & Mammography? ❑ **YES** ❑ **NO**

If "Yes" please check the reasons that apply: ❑ Medical Insurance ❑ Financial Difficulties ❑ Moving ❑ Other
If "No" please check the reasons that apply: ❑ For my own records ❑ Other _____
❑ Appointment with a breast surgeon or oncologist. When? _____

PATIENT AUTHORIZATION (***READ THIS SECTION TO PATIENTS MAKING VERBAL REQUESTS VIA PHONE***)

I understand that this authorization shall become effective immediately and shall remain in effect until three months from the date of signature, or until I revoke it in writing, whichever comes first. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
Additionally, I understand that authorizing another person to pick up my records can include disclosure of services rendered, insurance payments and/or denials, all demographic information, which can include date of birth, policy number, home address, telephone number, employer, and any other private information on my behalf.
I authorize the above name Imaging Center/Medical Center to release medical records and information pertaining to diagnostic reports and/or images for the above named patient.

Signature of person requesting records: _____ **Date:** _____
If submitted by mail, email or fax, Patient Signature was compared to signature on file: ❑ **Yes** ❑ **No**
Authorization in paragraph above taken by verbal order as document at top of form: ❑ **Yes** ❑ **No**
***If Authorized Representative, relationship to patient:** _____

OPTIONS FOR OBTAINING MEDICAL RECORDS - Please choose one

☐ Pick up at the office (We will notify you when your records are ready.)
☐ Deliver records to the below address via the United States Postal Service (USPS)

Name/Facility:		Phone #:	
Address:		Apt #:	
City:		Zip Code:	

ID VERIFICATION OF PERSON PICKING UP OR INTERPRETING MEDICAL RECORDS

Patient / Authorized Representative **IDENTIFICATION** was verified by viewing photo ID: ❑ **Yes** ❑ **No**
Print Name: _____ Date: _____
Signature: _____ Relationship to patient: _____

FOR INTERNAL USE ONLY

Medical records prepared and verified by (employee signature) _____
Medical records verified and released by (employee signature) _____
Patient Name: **MRN:**