RADIOLOGY & MRI
of Bethlehem, Inc.

5325 Northgate Drive (Suite 100) Bethlehem PA
610.691.8931
rmribethlehem.com

Patient Information Release

Date _____ Patient Name _____

Address _____

Date of Birth _____ Social Security # _____

Patient Signature to release information

_____

Parent/Guardian Signature to release information (if patient is under 18)

_____

The above identified patient is authorizing their medical information be made available to all doctors/ hospitals/medical facilities/health plans involved in their care and the following family members or friends.

List full name and relationship of persons you authorize us to release your diagnostic imaging records to. We will not release your diagnostic imaging records to anyone (family members included) not on your authorized list. Please list **ONLY** the names of family members or friends, **NOT INCLUDING DOCTORS**.

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At **Radiology and MRI of Bethlehem**, we strive to keep your diagnostic imaging records and your health information private. Only you can authorize us to release your records to someone else. In the interest of the staff's time, please let your family or friends know who you designated as persons authorized to pick up your imaging records.

WE MAY HAVE TO REFUSE TO RELEASE YOUR RECORDS TO ANYONE NOT ON YOUR LIST.

24 HOUR NOTICE IS REQUIRED FOR FILM PICK-UP

Radiology and MRI of Bethlehem

Authorization to Obtain Medical Records

In compliance with HIPAA, the Health Insurance Portability and Accountability Act of 1996, I hereby authorize Radiology and MRI of Bethlehem, Inc. to obtain any medical records (i.e. films, reports, biopsy/pathology reports, etc.) from any doctor/hospital/medical facility involved in my care to assist in evaluating my diagnostic imaging studies.

Patient Name _____ Date of Birth _____

Patient Signature _____

Parent/Guardian Signature to release information (if patient is under 18)

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