BRIGHAM HEALTH
BRIGHAM AND WOMEN'S HOSPITAL

Image Service Center

75 Francis Street
Boston, MA 02115
Telephone: (617) 732-7180
Fax: (617) 732-5300

Authorization for Release of Medical Images Information

Patient Name: _____ **Date of Request:** _____
(print please)

Medical Record #: _____ **Date of Birth:** _____

I hereby authorize Brigham and Women's Hospital furnish medical images and Radiology Reports from my image file to:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Date of Exam(s): _____

Exam(s): _____

_____.

(Specific Information Required., *Print please)*

Digital images on CD should not be returned. I understand that the Compact Discs (CD) to be released contains a copy of my medical images. I hereby release the Brigham And Women's Hospital, Inc. and its agents and employees from all liability that may arise from the release of the Compact Disc (CD).

I understand this policy as it has been explained to me.

I acknowledge receiving _____ CDs,_____ ORIGINAL Films _____ Radiology Reports.

(Check all that apply)

Thank you in advance for handling these images with care and, if you are borrowing original films, for returning them to the Brigham and Women's Image Service Center.

_____ _____

Date Patient Signature or Signature of Presenter *(if not Patient)*

_____ _____

ISR Initials: Relationship of Presenter

__ **Positive ID Presented**