[ ] Mail Out Date: _____
[ ] Pick Up Date: _____

Chambersburg Hospital
112 North Seventh St.
Chambersburg, PA 17201
**717-267-7150**

Rhonda Brake Schreiner Women's Center
12 St. Paul Drive, Suite 103
Chambersburg, PA 17201
**717-217-6750**

Waynesboro Hospital
501 East Main Street
Waynesboro, PA 17268
**717-765-3404**

# AUTHORIZATION FOR RELEASE OF RADIOLOGY INFORMATION

**HSM#:** _____ **MR#:** _____ **DOB:** _____

**Complete patient name and also address:** **Date of upcoming appointment:** _____

_____
_____
_____

Telephone # _____

List Name, Phone & Address of provider requiring the images or individual retrieving the images:
_____
_____
_____

**[ ]** Report only requested **[ ]** Images and Reports requested

Radiology Images Needed with Date of Study: _____

I acknowledge receipt of original radiology images (Mammograms only) and I understand that these images are the property of the facility named above. I agree to return these images to the facility named above. CDs do not need to be returned.
**Please Note: All patients should consult their physician for information regarding the interpretation of their test results.**

## GENERAL AUTHORIZATION:

I understand and acknowledge that this authorization allows the entity outlined above to release all of the records indicated above with the exception of the specially protected health information referred to under the Special Authorization section of this form. I understand that, **on occasion,** general information may be released by telephone or fax.

(1) I understand that I may revoke this Authorization at any time, except to the extent that action based on this Authorization has been taken, by sending a letter signed by me to: Privacy Officer, Summit Health, 112 North 7th Street, Chambersburg, Pa.
(2) The entity outlined above may not condition treatment on my agreement to sign this Authorization.
(3) Information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipients listed above and may no longer be protected.
(4) This Authorization is fully understood by me and is made voluntary on my part.

Patient's Signature:_____ Date:_____ Time:_____

Signature of Witness Required Signature of Parent/Guardian or Legal Representative (if signed by other than patient, state relationship and reason for patient's inability to sign)
Relationship: _____
Reason for patient's inability to sign: _____

_____
This form has been read and explained to me, I fully understand its contents, and I verbally authorize the release of information describe above.

Date Signed: _____ Time Signed: _____

Witness #1 Printed Name: _____ Witness #2 Printed Name: _____

Witness #1 Signature: _____Witness #2 Signature: _____

Patient Label

MR.AFROR