___ RIA at Pembrooke (301) 870-8434, (301) 870-5327 fax
___ RIA at Heritage (301) 856-3670, (301) 868-0129 fax
___ RIA at The Breast Center (301) 856-2420, (301) 868-2481 fax
___ RIA at Patuxent (301) 855-9754, (301) 855-1367 fax
___ RIA at Sterling (703) 450-5800, (703) 450-0495 fax
___ RIA at Lansdowne (703) 858-0001, (703) 724-0600 fax

Joseph P. Finizio, M.D., Medical Director

# PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

REQUESTED PICK-UP DATE: _____ TIME: _____

PATIENT'S NAME: _____ DOB: _____

X-RAY #: _____ PATIENT #: _____ LDOS: _____ PHONE:#:_____

TODAY'S DATE: _____TIME:_____ COMPLETED BY: _____

**TYPE of MEDIA / EXAM REQUESTED**

□ **CD** _____

□ **FILM COPIES** _____

□ **FILM ORIGINALS **** _____

Records prepared by: _____

## Patient Authorization

- I authorize RIA/NVI, LLC to release my medical imaging records including my radiographs, professional interpretations, reports, and other medical information to the "Authorized Person" whose name appears below. I understand that this authorization will not transfer to another person.

  To: Me _____, My spouse _____, My parent _____, Legal guardian_____, My child _____,

  Name and relation of person other than me: _____

- ** I understand that original films are the property of RIA/NVI, LLC. I agree to return these original medical imaging records, for safekeeping, as soon as practical after my doctor is finished with them. I agree to accept full responsibility for any loss or damage to these films during the period that the films are not within the sole, exclusive possession of RIA or NVI, LLC.

- I understand that only one copy of these images on this media will be provided without charge. Additional copies will be $10.00 for CD and $10.00 per sheet of copy film.

- REASON FOR RECORDS / FILM RELEASE
  - □ Providing images for Dr. _____ □ Moving out of area: _____
  - □ Changing radiology provider? Who? _____

    Why are you using another provider? _____
  - □ Other: _____

**Patient signature: _____ Date:_____**

**Authorized recipient: _____ Date:_____**

**Sign-out witness: _____**

RIA 237, rev. 11/8/10