Request for Release of Information

Radiology Only

PLEASE COMPLETE ALL FIELDS

Patient's Name: _____ Date of Birth: _____

Address: _____

City State Zip Code

Phone: _____ Email: _____

Who will disclose the information? HSS is authorized to disclose the information described below.

Who will use and/or receive the information? The person(s), or class of persons, authorized to use and/or receive the information:

Name: _____

Address: _____

City State Zip Code

Phone: _____ Fax: _____

Immediate Access to Images: You can access your images, notes, and reports through your online portal at www.hss.edu/myhss free of charge.

Please check all boxes that apply

I am requesting a copy of the Radiology Images on a Disc of my ☐ X-Ray ☐ MRI

for exam date(s) _____

What is the purpose of the use or disclosure? (check where applicable)

☐ Patient's Request	☐ Medical Care	☐ Insurance
☐ Immunization	☐ Legal	☐ Other: _____
☐ Support for an application, claim or appeal for a government benefit or government program		

Request:

☐ I will personally pick up the disc ☐ Mail to me at the above address

Hospital for Special Surgery is the custodian of all Radiologic Films/Images and therefore must maintain originals. HSS is permitted to impose a reasonable charge to offset the cost of copies provided.

Please see fee schedule:

Picking up disc(s) in person are $15 each Disc(s) to be mailed are $35 each (via FedEx Ground)

When will this authorization expire? One (1) year from date signed, unless a date / event is specified below:

_____

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Please fill out the form and return to us:

1. Hand deliver in Office
2. Fax to: 561.657.4674
3. Email to: floridaimagerequests@hss.edu

***Copies can be picked up Monday-Friday from 8:00am-4:00pm at our above listed address. Please see registration/ greeter in first floor lobby. Discs will be held for 30 days.**

Signature of Patient or Personal Representative*	Print Name of Patient or Personal Representative
Description of Personal Representative's Authority	Date

If you are making a request for records on behalf of a child (ages 12-17) – the child must authorize you to receive records on his/her behalf as required by NYS Public Health Law § 17 & 18.

Signature of Adolescent Patient	Date

OFFICE USE ONLY

MRN: _____ **Clerk Initials:** _____