Guam Radiology Consultants

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient's Name:_____ Date of Birth _____

I authorize **Guam Radiology Consultants** to Release or Request copies of Medical Records and X-rays for the course of my examination or treatment at this facility. A photocopy or fax copy of this authorization will serve as an original. I understand that the information on this form may be released to other health care providers or entities. I also direct any facilities receiving a copy of this form to release original or copies of all exams including original mammograms, reports of results of exams, clinic notes, pathology reports and/or any other information relating to my care requested by **Guam Radiology Consultants.**

This form, unless directed by me to be invalidated, shall remain effective for twenty-four (24) months from the date of my signature.

Please note that Federal Law requires your facility to release the patient's original mammographic images to our facility. You are directed not to provide copies. We are requesting the original images. If the exams are digital, we have a DICOM based RIS/PACS and request a CD or DVD with such studies in a DICOM format.

The FDA and our facility encourage you and your facility not to charge the patient to forward her exams to our facility. We do not charge for such services. If you elect to charge the patient, you are required by law to charge no more than the documented expenses.

Patient's or Guardian's Signature: _____ Date: _____