MUNSON HEALTHCARE
Traverse City, MI 49684

☐ Kalkaska Memorial Health Center
☐ Munson Healthcare Cadillac Hospital
☐ Munson Healthcare Grayling Hospital
☐ Munson Medical Center
☐ Paul Oliver Memorial Hospital

Authorization For Release of Radiology Images and Reports

Name:_____ DOB:_____ MR#_____

Address:_____ City:_____ Zip Code:_____

I,_____ hereby authorize **Munson Healthcare Radiology Department**
(Name)
it's Director designee, or Health Information Department, to release information contained in my patient records, **including alcohol and drug abuse records** protected under the regulations in 42 Code of Federal Regulations, Part 2, if any, **social services records**, if any, and **psychological services records**, if any, **including communications made by me to a social worker or psychologist**, if any, and all information defined by statute and Michigan Department of Public Health Rules (Public Act 174,1989) **governing Human Immunodeficiency Virus (HIV), HIV Test, Acquired Immunodeficiency Syndrome (AIDS),** and **AIDS-related complex (ARC)**, if any, to the individual or organizations listed below, only under the conditions listed below:

To:_____
(Name of person(s) or organization to whom disclosure is to be made)

Attention:_____ Address:_____

City: _____ Zip Code:_____

☐ **PATIENT REQUEST FOR PERSONAL USE**
☐ **RELEASE OF IMAGES FOR CONTINUATION OF CARE** ☐ **INCLUDING COPY OF INTERPRETATION REPORT**

I am requesting the release of my images for a consultation outside of the Munson Healthcare system. **These images are the property of Munson Healthcare.** (There will be a charge for expedited delivery by Federal Express)

- I understand that my radiology file may contain reports and images that only a physician can interpret.
- I understand that I should contact my physician with any questions regarding my radiology file.
- I agree that Munson is not responsible for any misinterpretation of the information in my medical record as a result of not having consulted my physician for the correct interpretation.

DATE(S) AND TYPE OF IMAGE(S) TO BE RELEASED:

This authorization is subject to a written revocation at any time except in those circumstances in which the hospital has taken certain actions in reliance on such authorization.

SIGNATURE **X**	DATE	WITNESS	DATE
RELATIONSHIP TO PATIENT	IF PATIENT IS A MINOR OR INCAPABLE OF SIGNING, THE SIGNATURE OF THE RESPONSIBLE PERSON AND THEIR RELATIONSHIP TO THE PATIENT IS NECESSARY.		

☐ DRIVER'S LICENSE / IDENTIFICATION VERIFIED, AS APPLICABLE

AUTHORIZATION FOR RELEASE OF RADIOLOGY IMAGES AND REPORTS