SOUTHERN NEW HAMPSHIRE RADIOLOGY CONSULTANTS, PC
703 Riverway Place
Bedford, NH 03110
Ph - 603.627.1661
Fax - 603.669.6944

X-RAY FILM RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Date: _____ X-Ray #: _____

Name		Date of birth	
Address			

I hereby authorize Southern New Hampshire Radiology Consultants, PC to use and/or disclose my individually identifiable health information as described below:

Type of x-ray films to be released: _____

_____

_____

Date(s) of service: From: _____ To: _____

The x-ray films shall be disclosed/delivered to:

Name: _____

Address: _____

_____

The purpose of this disclosure is:	☐ Insurance	☐ Legal matter	☐ Medical care	☐ Personal

My signature below indicates that upon my possession, I take full responsibility of the films until returned, knowing that they are part of the permanent medical record and property of Southern New Hampshire Radiology Consultants, P.C.

_____ _____

Signature of Patient or Representative Date

_____ _____

Printed name of Patient or Representative Relationship to patient