Lexington Clinic

# Radiology Release of Information Procedures

The Radiology Release of Information Department is open Monday through Friday, 8:00 a.m. to 4:30 p.m. Our staff can be contacted at (859) 258-4047. Please fill out the Radiology Release of Information Form on the next page by following the instructions below:

- We request that you allow a minimum of 24 hours to process your request for the release of radiology images.
- Radiology images that are loaned out for pick-up will be waiting at the radiology check-in desk on the 1st floor of the main building at 1221 South Broadway, unless other arrangements are made.
- If picking up images, proper identification and/or written authorization from the patient will be required prior to the images being released.

## WRITTEN REQUESTS OF WRITTEN AUTHORIZATIONS MUST CONTAIN THE FOLLOWING INFORMATION:

- Addressed to the Lexington Clinic.
- Specifically identify the patient.
- Specifically identify the recipient of the information. Medical record information will not be released to a person who is not indicated on the release form.
- Specifically identify the information to be released.
- Signed by the patient or his/her legal representative.
- Be received within one year of the date of the signature and the date of the request for information.
- Indicate if the images are to be picked up by the requester or mailed to the address given.

## WHO CAN SIGN A PATIENT AUTHORIZATION?

- Patient
- Legal representative
- In the case of a minor (under 18 years of age), the parent or guardian should sign the authorization.
- In the case of a minor (under 18 years of age) whose parents are divorced, the custodial parent should sign any authorization.
- In the case of a disabled patient, the Power of Attorney (POA) can sign the authorization, but a copy of the POA must accompany the request.
- In the case of a deceased patient, the administrator or executor of estate can sign the authorization.

## VERBAL REQUESTS

When a verbal request (phone call) is received for the release of medical information, the requestor is informed that a release of medical information authorization form will be required prior to processing of the request unless the images are to be picked up by the patient. If the images are to be picked up by the patient, the request can be processed and a release of information signed by the patient at the time of pick up. If images are to be mailed, the release form can either be faxed or mailed to the Lexington Clinic.

Lexington Clinic

# Authorization for the Release of Radiology Images

## 1) Tell Us About The Patient

| Name: | | Phone: |
|---|---|---|
| DOB: | SSN: X X X - X X - | MRN: |
| Address: | | |
| City: | State: | Zip: |

## 2) Where And How Are We Sending The Images?

| Send To: | Method of Retrieval: ☐ Mail ☐ Pick Up ☐ Fax _____ |
|---|---|
| Mail to Address: | |
| City: | State: Zip: |

## 3) What Information Would You Like Released?

☐ Provider(s) _____ ☐ All Clinic Providers

☐ Images covering period of time: _____ to _____ ☐ All dates of treatment

☐ Images regarding treatment for the following condition(s) or injury(ies): _____

☐ Other _____

## 4) Purpose Of Disclosure

☐ Personal Use ☐ Transfer of Care ☐ Litigation/Legal ☐ Other

## 5) Patient's Signature

I understand this is the minimum amount of information necessary for the purpose described above. No other information will be disclosed. I understand I have the right to revoke this authorization, in writing, at any time, by sending such notification to the Director of Health Information at the address noted on this form. I understand my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand Lexington Clinic may not condition my treatment or payment on whether I choose to sign this authorization. I understand information used/disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. I understand this authorization expires in 1 year from date of signature unless a specific date/event is listed _____. I understand I will receive a copy of this authorization. I understand this authorization must be filled out in its entirety to ensure timely release of my information.

| Signature of Patient or Authorized Person: | Date: |
|---|---|
| Authorized Person's Relationship: | Reason Patient Unable to Sign (if applicable): |

Lexington Clinic Employees: This authorization does not permit usage of our computer systems to access your / a family member's patient information.

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