Home Health Radiology Services
"A Better Portable Service" for New Jersey's Visiting Physicians

Phone (908) 624-9869 Toll-Free (888) 964-0088 Fax (866) 498-0867 or (908) 241-2194

Authorization For Use and Disclosure of Diagnostic Medical Images and Reports

Completion of this document authorizes the disclosure and/or use of identifiable health information, as set forth below, consistent with Federal law concerning the privacy of such information. Failure to provide all information requested, including the pre-payment processing fee, might invalidate or delay the processing of this Authorization.

Patient: _____ Date of Birth _____

Medical Record Number: _____ Date of Exam: _____

Patient/Physician Requiring CD: _____ Phone Number: _____

Address: _____

Patient Consent for Release of Original X-Ray Exams

In your interest, we are glad to cooperate by loaning CDs of your X-rays to the physician's clinic or hospital of your choice. It must be remembered that the X-rays are our legal property and we are legally responsible for their care and custody. For X-rays more than a year old, 48 hours' notice is needed. The CD does not need to be returned.

To be completed by Home Health Radiology Services Staff:

Number of CDs given _____ Number of CDs mailed out _____ Number of CDs taken by patient _____

Authorized by: _____ Verbal: _____ Written _____

To be completed by the patient:

I understand that the CD I am about to take is part of the permanent record of Home Health Radiology Services and I am personally requesting release of my x-Ray exam.

Signed _____

Witnessed by: _____ Date _____

Summary For Copies of CD

*Fax completed form to **(866) 498 0867**, or mail to:*
Home Health Radiology Services PO Box 2092, Union NJ 07033

No charge for first CD of above exam. $10 charge for each additional CD of above exam.

Number of CDs given @ $10 per CD = $ _____ Total Amount