

Clinton Memorial Hospital Authorization For the Release Of Radiology Images

Clinton Memorial Hospital
Radiology Department
805 S. Oakland St.
St. Johns, MI 48879

989-227-3330
Fax 989-224-7303

By completing this form you are informing Clinton Memorial Hospital of your wish to designate the named person(s) as your authorized representative(s). You may revoke this designation at any time by signing and dating the revocation area below.

Patient Name: _____ SS# _____

Date of Birth: _____ Telephone # _____

Current Address: Street: _____

City: _____ State: _____ Zip: _____

Release Radiology Images/Reports to:

Name of Recipient: _____

Address: _____

Radiology Images to be released: _____

I hereby authorize Clinton Memorial Hospital to release my Radiology Images/Reports to the recipient(s) named above.

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to Clinton Memorial Hospital at the above address. Such revocation does not apply to the extent that persons authorized to obtain my protected health information have already acted in reliance on this designation.

Signature of Patient/Legal Guardian

Date signed

Relationship if not patient

Request to revoke designation of above named person(s):

Signature of Patient/Legal Guardian

Date signed