



011554

**MEDICAL IMAGING SERVICES
WINCHESTER MEDICAL CENTER
AUTHORIZATION FOR FILM RELEASE**

Medical Record # _____

Patient Name _____ Date of Birth _____ Telephone # _____

I hereby authorize Winchester Medical Center to release prints or copies of my radiological images and/or reports as described below:

Exam(s) requested	Exam dates	Exam(s) requested	Exam dates
Exam(s) requested	Exam dates	Exam(s) requested	Exam dates
Exam(s) requested	Exam dates	Exam(s) requested	Exam dates

_____ CD
_____ FILM

The disclosed information is to be used by the following individual or organization for the purpose of:

- Continuing Medical Care
- Personal
- Legal
- Other _____

Name of Healthcare Facility, Physician or Firm

To be picked up by _____ on _____
Name of individual Date

To be Fed Ex'd to _____ by _____
Name of Healthcare Facility, Physician or Firm Date needed

Name of Healthcare Facility, Physician or Firm (_____) Telephone #

Address _____

Address _____

City _____ State _____ Zip Code _____

* FedEx Tracking Number: _____ - _____ - _____