HUDSON VALLEY IMAGING

affiliated with St. Luke's Cornwall Hospital

575 Hudson Valley Ave., Suite 101, New Windsor, NY 12553
Ph 845-220-2222 Fax 845-220-2241

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Authorization for the Release of Health Information

DATE: _____
PATIENT:_____
DATE OF BIRTH:_____
DATE OF EXAM AT HVI:_____

If you have had any previous x-rays or other imaging studies related to the medical reason for your study and you did not bring the films and report with you, this form allows us to obtain those records for comparison purposes on your behalf.

REQUEST

To: _____
of: _____

I,_____ , hereby consent and authorize you to release to:

Hudson Valley Imaging
575 Hudson Valley Ave., Suite 101
New Windsor, NY 12553

Records to be released: _____
Date(s) of service: _____

Authorization

This authorization is given for the sole purpose of comparison with the study(s) performed at HVI. The films/ studies will returned to the original holder within 30 days of receipt. I understand that this authorization is subject to revocation at any time, except to the extent that the individual or entity that is to make the disclosure has already taken action in reliance upon it. I also understand and agree that this authorization will terminate only upon the execution of my written statement indicating my intent to revoke this authorization and that without such written revocation, this authorization shall remain in effect and shall not expire.

_____
Signature of Patient Date

If signed by other that the patient, please indicate relationship:
_____