Check office where you were seen:

☐ Alexandria Imaging Center
4660 Kenmore Avenue
Suites 525 and 608
Alexandria, VA 22304

☐ Woodbridge Imaging Center
4001 Prince William Parkway
Suite 302
Woodbridge, VA 22193

☐ Lorton Imaging Center
Note that this location permanently closed for business on June 27, 2008.

☐ Woodbridge X-ray Center
Note that this location permanently closed for business on June 26, 2009

Film #: _______________

Authorization to Disclose Health Information

PATIENT NAME: ____DATE OF BIRTH: ________________________
LAST FIRST MI

ADDRESS: ________________________________ CITY: ____________________ STATE: _____ ZIP: ___________

DAY PHONE: ______________________________ ALTERNATE PHONE: ______________________________

I hereby authorize Association of Alexandria Radiologists to release or disclose the information indicated below to:

NAME: ____

ADDRESS: ________________________________ CITY: ____________________ STATE: _____ ZIP: ___________

PHONE: __________________________________ FAX: ______________________________________

INFORMATION TO BE DISCLOSED:	**Dates**
☐ Consultation	________________________
☐ X-ray Films/Report Specify Exam ____________	________________________
☐ Billing Information	________________________
☐ Other________________________	________________________

PURPOSE OF DISCLOSURE: ☐ Medical Follow-up ☐ Personal Use
☐ Attorney ☐ Disability ☐ Insurance ☐ Workers Compensation
☐ Other (please specify): ____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I understand that I have the right to a copy of this authorization. I also understand written notification is required to revoke or modify this authorization. A request to modify or revoke this authorization should be sent to AAR at the address listed above. I understand that my revocation or modification of this authorization will not affect any disclosures made in reliance on this authorization before my request for revocation or modification was received by AAR.

Films: I understand that I am accepting full responsibility for the condition and location of films, if applicable and release AAR of any liability from loss or damage. These films remain the property of AAR and must be returned within 30 days. The return of CDs is not required. AAR is released from any and all liability that may arise from the release of such records and/or information. Proof of identity is required if the person signing release is not the patient.

____ ______________________________
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE DATE

____
IF SIGNED BY LEGAL REPRESENTATIVE SPECIFY RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST TAKEN: ______________________ BY: ______________________________

DATE PACKED UP:______________________BY:______________________________

OF FILMS SIGNED OUT____________________# OF FILMS RETURNED________________________

DATE PICKED UP: ______________________RELEASED BY:______________________________

IDENTIFICATION PRESENTED: ____