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***Authorization for Release of Radiology Images***

To request release of radiology images, please complete this form and return it to:

**Image Service Center**

**Boston Children’s Hospital**

**300 Longwood Avenue**

**Boston MA 02115**

Phone: 617-355-6283 Fax: 617-730-0538

🞐 Send images by mail

🞐 Email link to view images

🞐 I will pick up images in:

 🞐 Boston (Monday–Sunday, 7:00am-11:00pm)

🞐 Waltham (Monday–Friday, 7:00am-8:00pm)

9 Hope Avenue, Waltham, MA 02453 (781-216-1100)

**Picture I.D. required when picking up films/images.**

**Patient Information**

Last Name First Name MI

Street Address Apt.

City State Zip

Children’s MR# Home Telephone ( )

Date of Birth Alternate Telephone ( )

Email

***Children’s Hospital Boston has my permission to release information contained in the Image Service Center on the above named patient.***

**Information Requested** *(please be specific and enter the date of service if known):*

**Purpose of Release:**

***Children’s Hospital Boston will provide the information requested above to the following party:***

Name

Attention of Telephone

Street Address Suite/Room

City State Zip

I hereby authorize Children's Hospital Boston (Children’s) to release any radiology information as requested above. This includes films/images or other protected information unless otherwise excluded. I understand that Children's cannot control how the recipient uses or shares the information and that laws protecting it at Children’s may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire in 90 days from the signature date. I can, however, cancel this authorization in writing at any time, except to the extent that Children’s has relied upon it. For example, if I cancel the request after Children’s has sent requested records, Children’s will not retrieve those records. Instructions for canceling this authorization are included in the Children’s Notice of Privacy Practices. I understand that Children’s will continue to provide care, even if I do not authorize this release.

***Patient signature is required for patients who are 18 years or older, or who have emancipated minor status, or special condition as defined by law. Parent or legal guardian signature is required for patients under age 18 without emancipated status or a special condition.***

**Signature of Patient** **Date**

**Signature of Parent or Guardian Relationship to Patient Date**

**Please make a copy of this release for your records.**