

Image Service Center  
75 Francis Street  
Boston, MA 02115  
T: 617.732.7180  
F: 617.732.5300

## Authorization for Release of Medical Images Information

Patient Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_  
(Print please)

Medical Record #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ Receive images electronically?:  Yes  No

I hereby authorize Brigham and Women's Hospital furnish medical images and Radiology Reports from my image file to:

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Date of Exam(s): \_\_\_\_\_

Exam(s): \_\_\_\_\_

\_\_\_\_\_  
(Specific information required., Print please)

Digital images on CD should not be returned. You will receive an email with a link to access your imaging. I understand that the Compact Discs (CD) to be released contains a copy of my medical images. I hereby release the Brigham and Women's Hospital, Inc. and its agents and employees from all liability that may arise from the release of the Compact Disc (CD).

I understand this policy as it has been explained to me.

I acknowledge receiving  CDs,  Radiology Reports,  Electronic Copy. **(Check all that apply)**

Thank you in advance for handling these images with care and, if you are borrowing original films, for returning them to the Brigham and Women's Image Service Center.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature or Signature of Presenter (if not Patient)

\_\_\_\_\_  
ISR Initials:

\_\_\_\_\_  
Relationship of Presenter

Positive ID Presented