NCH Imaging

AUTHORIZATION FOR RELEASE OF RECORDS FROM ANOTHER FACILITY
This form needs to be emailed to Medicalrecordsxray@nchmd.org

1. PATIENT INFORMATION

Patient Name & Alias Name			
Street Address	City	State	Zip
Date of Birth (MM/DD/YYYY)	**Phone Number Required		

2. I AUTHORIZE RELEASE FROM:

_____
Name of Healthcare Provider

_____
Street Address

_____
City State Zip

Phone:_____ Fax:_____

3. I AUTHORIZE DISCLOSURE TO:

NCHI Medical Records Department
1715 Medical Blvd, Bldg B
Naples, FL 34110
Phone (239) 624-6660
Fax (239) 624-6661

4 PURPOSE OF DISCLOSURE: The purpose of this disclosure if for continuation of care/transferring care.

5. TYPE OF MEDIA OR EXAM TO BE RELEASED:

DATE OF SERVICE: _____

□ CD/DVD **□ REPORT(s)**

I understand that this Authorization is effective for a period of one (l) year from the date of signature, unless otherwise specified. I understand that I have the right to revoke this Authorization at any time by sending a written request to NCH Imaging Centers, except to the extent that action has already been taken. I understand that NCH Imaging Centers cannot require me to sign this Authorization as a condition for treatment. I understand that it is possible that re-disclosure of records may occur and that NCH Imaging Centers and its staff/employees have no responsibility or liability as a result of re-disclosure. I am entitled to a copy of this completed Authorization.

_____ _____
Patient Signature Date

_____ _____ _____
Patient Legal Representative Relationship Date