Authorization to Release Medical Images

Instructions: *If any section of this form is incomplete, this form may be invalid.*

1. Patient Information:

Name: *(First, MI, Last)*

Phone:

Date of Birth:

Current Address:

Email:

City:

State:

Zip:

Medical Record or FIN#: *(For Internal Use)*

2. Medical Information FROM (the "Provider"):

☐ Southwest General Health Center / Hospital

DO NOT USE THIS FORM for Southwest General Medical Group (SGMG) records. SGMG physician offices do not have the capability to accept online requests at this time. Refer to the SWGeneral.com / Patients & Visitors / Medical Records webpage for the standard Authorization form.

3. Release Information TO (the "Recipient"):

Name *(First, MI, Last)*:

Address:

City:

State:

Zip:

Phone:

Fax:

Delivery Method

☐ Mail CD

☐ Pick up CD *(M-F 8 a.m. – 4:30 p.m.)*

☐ Secure image access *(recipient's email required)*

4. Release the Following Image Records:

Please send the following specific image records:

Image Type (MRI, CT Scan, etc.)

Image Date:

OR send all images taken during the following date range: From: To:

Southwest General will send a link to your email address that will allow you to securely access and download your images from a cloud-based system.

Southwest General
Partnering with University Hospitals

Reason for request: ☐ Continuity of Care ☐ Personal ☐ Other *(specify)*:

This authorization will expire one year from the date of signing unless I indicate an earlier date or event here:

I, the undersigned, authorize the Provider listed in Section 2 to release medical information as indicated/described in Section 4 above. This authorization may be revoked in writing to the Radiology Department (address below). I understand revocation will not apply to information that has already been released in response to this authorization. I understand that once the information is released pursuant to this authorization, it may be re-disclosed by the Recipient and the information may not be protected by federal privacy regulations. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for physical or psychiatric condition, HIV test results, an AIDS diagnosis, and or alcohol/drug abuse. I expressly consent to the release of information as designated above.

ATTENTION RECIPIENT: If the records released include information of HIV-related diagnosis or test results, or any diagnosis or treatment from a substance abuse treatment program, the following statement applies: This information has been disclosed to you from confidential records protected from disclosure by State law or Federal Confidentiality Rules. These regulations prohibit you from making any further disclosure of this information without the specific written and informed consent of the individual to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal Rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client. (Ohio Revised Code 3701.243) & (42 C.F.R. Part 2) respectfully.

NOTE: Fees may apply to certain requests.

Signature of Patient or Personal Representative:

Date:

Relationship, if not patient:

Date Authorization Received:

Processed by *(init.)*:

I confirm that I am the patient named above and I understand and agree that by clicking "Submit" below, I am electronically signing this form and an electronic signature has the same effect as my written signature.

SUBMIT

If the person submitting the request for medical records is someone other than the patient or a parent of a minor patient (e.g., court appointed guardian; durable power of attorney), please include supporting documentation of your authority to act on behalf of the patient with your request.

If you have any questions, please call **(440) 816-8770**.
Southwest General Health Center, Radiology Dept · 18697 Bagley Road · Middleburg Heights, OH 44130