Radiology Authorization Form

Walter Reed National Military Medical Center

PATIENT INFO

FULL NAME: _____

DATE OF BIRTH: _____

PATIENT'S 10 DIGIT DOD ID #: _____

PHONE #: _____

FULL MAILING ADDRESS:

_____

I _____ authorize the Walter Reed
(PRINT PATIENT'S NAME)
Bethesda Radiology Department to release a copy of my Radiology Imaging to:
_____.
(PRINT RECIPIENT'S NAME)

EXAMS and DATES COMPLETED (MUST PROVIDE SPECIFIC EXAMS BEING REQUESTED)

_____

_____

_____

I UNDERSTAND THAT:

a. This authorization is for this imaging disc request only, and any future request will require a new release authorization form.
b. If I authorize my protected health information to be disclosed to someone who is not required to comply with federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.
c. I have a right to inspect and receive a copy of my own protected health information to be used or disclosed, in accordance with the requirements of the federal privacy protection regulations found in the Privacy Act and 45 CFR ss 164.524.
d. The Military Health System (which includes the TRICARE Health Plan) may not condition treatment in MTFs/DTFs, payment by the TRICARE Health Plan, enrollment in the TRICARE Health Plan or eligibility for TRICARE Health Plan benefits on failure to obtain this authorization.
I request and authorize the named provider/treatment facility/TRICARE Health Plan to release the information described above to the named individual/organization indicated.

PATIENT ONLY

PRINT: _____

SIGN: _____

REQUIRED: Clear color copy of the front and back of the Patient's valid government issued ID Card (DoD ID, VA ID, State Issued ID, or Passport).