South Shore Medical Center

143 Longwater Drive, Norwell, MA. 02061 5 Tarkiln Road, Kingston, MA 02364 (781)-878-5200 (781)-585-2200

Medical Record #:	
Pick Up Date:	

Authorization to Release Radiology Diagnostic Images/Reports

2.	Patient's Name: (please print) 3. Date of Birth:							
2.	(please print)			_ 5. Da	ite of Bir			
4.	Address:		G:			G		
	Street		City			State	Zip	
5.	Images/reports to be disclosed t	0:	F	- :1:4				
		Name of Per	SON OF F	acility				
	Address: Street		City			State	Zip	
			City			State	2.19	
6.	Patient's Telephone #:							
7.	Please check items you are requ	esting.						
	☐ X-ray images/reports	Date:		Descrip	tion:			
	☐ Ultrasound images/reports	Date:		Descrip	tion:			
8.	The above information is disclosed for the following purpose(s):							
	☐ Medical Care	□ Legal		Insuranc	e	☐ Personal		
9.	I have carefully read and unders disclosure of the above informat physician, South Shore Medical of this information to such perso substantially in accordance with time by requesting such of the a begun. I understand that this au	center and its emplors or agencies name applicable law. I unbove-referenced Me	s and/or a oyees from ed above nderstand dical Ce	agencies om any le , provide d that thi nter in w	named a egal liabi ed the dis s authori riting, ur	bove. I further release lity arising from the di closure of this informa zation is subject to rev aless action based on it	e my attending isclosure ation is done ocation at any	
10.				11.				
	Signature of Patient or Author	zed Representative				Date		
12.	Printed Name of Patient or Leg	1.D	-	13.	D. 1:	The second second		
	rimed name of Patient of Leg	gai Kepresentative			for patie	nship to patient or authent	iority to act	