TOWER
Radiology Centers

NUMBERS OF CD'S _____

AMOUNT DUE: _____

PID# _____

MEDICAL RECORD RELEASE FORM
of PATIENT HEALTH INFORMATION (PHI)
Phone: (813) 875-7424; Fax: (813) 872-2799 (Attn: CMR Manager)

Date of Request:_____ Date Required: _____ Time: _____ Pick Up Site:_____
(if applicable)

Patient Name: _____ DOB: _____ Phone #: _____
(PLEASE PRINT)

The undersigned requests and authorizes Tower Radiology to provide personal health information to:

Name (Medical Facility):_____
Address:_____
City, State, Zip:_____

The method I would like my personal health information provided is:

○ Mail record to above medical facility ○ I, or an authorized person, will pick up health information (proper ID and letter required)*

○ ***Mail Outside Facility's Medical Records to Tower Radiology for Comparison*:**
Tower Radiology Central Medical Records Dept.,Attn:Luana Simpkins//Bob Siwiecki
2728 University Square Dr.,Tampa,FL.33612
This information, for which I am authorizing disclosure, will be used for the following purpose(s):

○ Continuing Medical Care ○ Personal Use ○ Information for Insurance Company
○ Information for Attorney ○ Comparison ○ Other:_____

Media Requested: ○CD ○ Report

Date of Exam:_____ **Type of Exam**:_____
_____ _____
_____ _____

I, _____, hereby voluntarily authorize the disclosure of information from my
(Patient, Parent or Guardian)
health record. This authorization will expire one year from the date of this request. However, each time new records are requested, a new request is required. This authorization is not valid if not filled out completely. A copy of this consent is as valid as the original.

I understand that the information outlined in this release will be disclosed according to the instructions of this release within (5) business days of Tower Imaging, Inc. having received this release authorization. I understand that I am free to revoke this release authorization at any time by notification in writing to Tower Imaging, Inc., Attn: HIPAA Privacy Officer, 2700 University Square Dr., Tampa, FL 33612.

CD'S ONLY

There is a $5.00 charge for CD'S given to the patient. **PLEASE DO NOT RETURN THEM. If you do return them, they will be destroyed.** If the patient wants another copy of the CD, even if they were returned to us, the patient will be responsible for paying for **ALL ADDITIONAL CD'S AT $5.00 PER DISC.**

Signature: _____ Date: _____
(Patient, Parent or Guardian)

FOR OFFICE USE ONLY
PICKING UP PROTECTED HEALTH INFORMATION REQUIRES IDENTIFICATION

PID: _____Form of ID Provided:*_____ID VERIFIED & SCANNED: YES ○ NO ○
Employee signature: _____
Employee Requesting Images:_____Films/CD created and QC'd by:_____
REVOCATION:
This authorization was revoked on this ___ day of _____, 201___. Revocation letter/document must be attached.
SCAN THIS FORM IN THE MASTER FOLDER UNDER EVERY EXAM RELEASED*Anyone picking up PHI, must have a valid ID. The person authorized to retrieve PHI on behalf of the patient must have a signed letter from the patient before records can be released.