Divine Savior
HEALTHCARE

2817 New Pinery Rd.
P.O. Box 387
Portage, WI 53901
(608) 742-4131

WPU _____ **SEND OUT** _____
DATE _____

AUTHORIZATION FOR RELEASE OF ORIGINAL FILMS OR DISK

PATIENT'S NAME _____
PATIENT'S PHONE NUMBER **(Daytime)** _____
(Evening) _____
DOB _____ **X-RAY #** _____ **MED REC #** _____
PERSONNEL REQUESTING FILMS _____
FILMS/DISK TAKEN TO _____
ADDRESS _____
CITY, STATE, ZIP _____
PHONE NUMBER _____
ATTENTION _____

☐ **FILMS** ☐ **DISK**
(if films, must be for **SURGERY** only) **Date of Surgery** _____

X-rays of: Dated:

Mammo _____ **# of films**
Total Films _____
Disk _____

Tech Initials _____
Date _____

Expiration date: This authorization is good for one year or until (indicate date) _____

By signing this authorization, I am confirming that it accurately reflects my wishes. I authorize the release of my medical record in accordance with the specification listed above.

Signature of Patient / Legal Rep: _____ **Date & Time:** _____
(If signed by other than individual, state relationship with signature)

Relationship to patient: _____

☐ HCPOA for patient ☐ Parent or legal guardian of minor ☐ Other (specify): _____

Information Released by: ☐ Telephone ☐ Fax ☐ Mail ☐ Other _____

Employee Releasing Information: _____ **Date & Time:** _____

*** These films are part of our permanent records on this patient. We request that you return these films with the slip WITHIN 30 DAYS OF THE ABOVE DATE. Please help us keep our files current by returning these films promptly.

THANK YOU
RADIOLOGY DEPARTMENT
DIVINE SAVIOR HOSPITAL

Authorization For Release of Original Films — Filing Instruction

XRY-01 3/08

DATE FILED _____ TECH INITIALS _____