Lahey CLINIC

Diagnostic Radiology Department

Image Management Center

Authorization for Release of Diagnostic Images

Tel: 781-744-3208
Fax: 781-744-5363

Date: _____

Patient Name: _____

Patient Lahey Clinic Number: _____

Patient Date of Birth: _____

Type and Dates of Images (x-rays) being requested: _____

_____

Patient phone #: _____

❑ Send images to the following name and address:

Name: _____

Address: _____

_____

❑ Patient will pick up on _____

If the patient sends someone else to pick up the CD/FILMS, they must have a signed authorization from the patient before we can release them.

I am authorizing the release of the above images. The CD is mine to keep.

Signature of patient/legal guardian: _____

Fax this authorization to the IMC. A CD will be burned with the x-ray images on it.

If hard copies of the films are desired, there will be a cost to the patient. Please call the IMC for pricing information.

If you have any questions or are unsure of which images you need, please call us.

Please allow at least 2 business days for your request to be processed. We will do it sooner if possible.