ADIRONDACK RADIOLOGY ASSOCIATES, P.C.

Patient Name: ☐ Home Phone ☐ Day Phone ☐ Cell ☐ Text ☐ Portal

MR #: Date of Birth:

MEDICAL RELEASE OF INFORMATION: I hereby authorize Adirondack Radiology Associates, P.C. and its representatives to furnish medical information, including photographic or faxed copies of my records to my referring physician(s) and to my insurance company if requested. As patient or legal guardian of patient, I understand that payment for today's services is ultimately my responsibility. I also authorize a representative of ARA to speak with my insurance carrier on my behalf if required.

I understand that this office bills insurance as a courtesy and that payment of the charges for these services is my responsibility. A photographic copy of this authorization shall be as valid as the original.

PATIENTS WITH MEDICARE PLEASE READ AND SIGN: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

COMPENSATION / NO FAULT RELEASE:
I do hereby declare that the reason for todays exam is **not** in any way related to a **work injury** or a **motor vehicle accident**.

Referring Physician:

CC MD:

What other physicians do you want to receive a copy of today's report? ***Please provide physician first and last name as well as mailing address or fax number to ensure proper delivery.***

_____

My personal health information can be released to:

_____

Signature of Patient, Parent or Legal Guardian:

_____

Witness: _____

Date of Service: _____