ADIRONDACK RADIOLOGY

RELEASE TO OBTAIN PROTECTED HEALTH INFORMATION FROM OUTSIDE FACILITY

Printed on: _____ User: _____

PATIENT NAME: _____

PATIENT DOB: _____ ARA PATIENT MR #: _____

OUTSIDE FACILITY: _____

ADDRESS: _____

_____

PHONE: (_____) _____ FAX: (_____) _____

PATIENT NAME AT TIME IMAGES PERFORMED IF DIFFERENT THAN ABOVE: _____

By signing this authorization, I authorize the above-named facility to release (check all that apply) the protected health information (PHI) indicated below that is about myself, or the above-named patient for whom I can sign, to the Adirondack Radiology Associates, PC facility indicated below

_____ Radiology Images _____

_____ Written Reports _____

_____ Laboratory Reports _____

- **Adirondack Radiology North Country**
  170 Carey Road, Queensbury, NY 12804
  P: 518-793-1000 F: 518-615-0390
- **Adirondack Radiology Saratoga Imaging**
  3 Care Lane, Suite 100, Saratoga Springs, NY 12866
  P: 518-583-7773 F: 518-583-4436
- **Adirondack Radiology Albany**
  1365 Washington Avenue, Albany, NY 12206
  P: 518-465-6501 F: 518-689-5350
- **Advanced Imaging at Baybrook**
  22 Willowbrook Road, Queensbury, NY 12804
  P: 518-926-7002 F: 518-798-1057

This authorization permits the above facility to use or disclose the individually identifiable health information.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

DATE: _____/_____/_____ WITNESS: _____