Delaney Radiologists

Please allow 48 business hours for requests to be processed.

MEDICAL RECORDS RELEASE/REQUEST FORM

Please fax request to (910) 332-0387

Patient name: _____ Date of birth: _____

Address: _____

Phone #: _____ MR#: _____

Records Are To Be:

- ☐ Picked Up By Patient
- ☐ Picked Up By Authorized Representative*
- ☐ Mailed*
- ☐ Faxed*
- ☐ Report Only ☐ Images on CD

*Please complete Send/Release section

Send/Release Records To:

_____
Name of Person or Entity Authorized to Receive Information

_____
Street Address

_____
City, State & Zip Code

_____
Phone # or Fax # (if they are to be faxed)

Records Requested:

- ☐ X-Ray _____ Date / _____ Date
- ☐ Mammogram _____ Date / _____ Date
- ☐ Ultrasound of _____ Body Part / _____ Date
- ☐ CT Scan of _____ Body Part / _____ Date
- ☐ MRI _____ Body Part / _____ Date
- ☐ Dexa _____ Date / _____ Date
- ☐ All records from _____ Date to _____ Date

_____ _____
Signature of Patient (or guardian, if minor) Date

_____
Print Name

To Be Completed By Employee:

_____ _____ _____
Request Completed By Date Identification Verified By