



**Diagnostic Study Release**

Pick Up Date \_\_\_\_\_

Prepared By \_\_\_\_\_

I do hereby authorize Health Village Imaging to disclose information from my medical record relating to my diagnostic study. I understand that this consent will serve as a complete release of liability to Health Village Imaging and its employees for the release of information/films/CD.

I authorize Health Village Imaging to release:

- Copies of my reports
- CD of my diagnostic study
- Films of my diagnostic study
- Images of my diagnostic study printed  
On paper

Exam type and/or dates \_\_\_\_\_

Released to: \_\_\_\_\_

Patient Name \_\_\_\_\_ MR# \_\_\_\_\_

DOB \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

(released by)

\*\*\* Ask the patient or representative for ID.