UNIVERSITY Imaging
St Joseph's Wayne Hospital

Medical Record and Film Release Authorization

Patient's Name _____ Date of Birth _____

By signing this release form, you acknowledge receipt of the original medical record(s) and films which comprise the complete examination performed on the aforementioned date at the University Imaging Center, St. Joseph's Wayne Hospital, High Mountain Radiology, Radiology Imaging Associates or Wayne MRI.

You further understand that the original films are the ONLY original films that exist. Therefore, patient releases and gives up any and all claims against University Imaging Center, St. Joseph's Wayne Hospital, High Mountain Radiology, Radiology Imaging Associates or Wayne MRI for loss, damage or destruction of the aforementioned film while in patient's possession.

By signing this release, patient understands and agrees to the terms of this release.

Name _____ Signature_____

If patient is not the party receiving the film, please state relation to the patient.

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