Beth Israel Deaconess Hospital
*Plymouth*

**AUTHORIZATION TO USE AND/OR DISCLOSE**
**DIAGNOSTIC IMAGING MEDICAL INFORMATION**
(Sections 2-8 must be completed)

1. I hereby authorize Beth Israel Deaconess Hospital-Plymouth ("BID-Plymouth"), to use and/or disclose the following protected health information ("PHI") from the diagnostic imaging records of the patient listed below. I understand that the information used and/or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. **Patient Name:** _____ **Date of Birth:** _____ **MRN#:** _____

   Address: _____
   Street City State Zip
   Phone Number: _____

3. **Diagnostic Imaging Information to be disclosed to:** _____
   Name
   Address: _____
   Street City State Zip

4. **Disclose the following Diagnostic Imaging medical information:** ☐ Studies/Images/Reports ☐ Report Only

   ☐Ultrasound ☐ CT Scan ☐ MRI ☐ NM ☐ X-ray ☐ Other: _____

   Exam _____ Date of Study _____
   Exam _____ Date of Study _____
   Exam _____ Date of Study _____
   Exam _____ Date of Study _____

5. The above information is disclosed for the following purpose: ☐Medical Care ☐Legal ☐Insurance ☐Personal

6. The means of delivery for the above information: ☐In person ☐Mail

7. I understand I may revoke this authorization at any time by requesting such of the above-referenced hospital, physician, or facility, in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. This authorization expires after ninety (90) days from the date I signed it unless otherwise specified.

   _____ _____
   Signature of Patient or Legal Representative Date

   _____ _____
   Printed name of Patient or Legal Representative Relationship to Patient or authority to act for patient **(attach documentation)**

8. I understand that my record may contain information in reference to treatment for substance abuse, alcohol abuse, psychiatric treatment or other sensitive information. I agree to its release unless otherwise specified. (please explain).

   _____ _____
   Signature of Patient or Legal Representative Date

   _____ _____
   Printed name of Patient or Legal Representative Relationship to Patient or authority to act for patient **(attach documentation)**

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SIGNATURE OF EMPLOYEE RELEASING RECORD/S_____ DATE: _____
*** You must review photo identification, completed form, and contents of CD prior to releasing results *** (Rev. 03/07/19)