Authorization to Release Diagnostic Images/Reports

Florida Hospital Altamonte
601 East Altamonte Drive
Altamonte Springs, FL 32701
P: (407) 303-2200

Florida Hospital Apopka
201 North Park Avenue
Apopka, FL 32703
P: (407) 889-1000

Florida Hospital Celebration Health
400 Celebration Place
Celebration, FL 34747
P: (407) 764-4000

Florida Hospital East Orlando
7727 Lake Underhill Road
Orlando, FL 32822
P: (407) 303-8110

Florida Hospital for Women
601 East Rollins Street
Orlando, FL 32803
P: (407) 303-4437

Florida Hospital Orlando
601 East Rollins Street
Orlando, FL 32803
P: (407) 303-5600

Florida Hospital Kissimmee
2450 North Orange Blossom Trail
Kissimmee, FL 34744
P: (407) 846-4343

Winter Park Memorial Hospital
200 North Lakemont Avenue
Winter Park, FL 32792
P: (407) 646-7000

Florida Hospital Winter Garden
2000 Fowler Grove Boulevard
Winter Garden, FL 34787
P: (407) 303-9611

Patient Name: ______________________________ Date of Birth: ______________

Address: ______________________________

Service Date(s): ______________ Medical Information to be Released: ______________

- ☐ Mammograms
- ☐ X-Rays
- ☐ MRI
- ☐ CT
- ☐ Ultrasound/Sonogram
- ☐ Special Procedure
- ☐ Other:

What are you requesting? ☐ Films/Images ☐ CD ☐ Report only

Would you like to pick up requested information? ______ If yes, at what facility?

☐ Altamonte ☐ Apopka ☐ Celebration Health ☐ East Orlando ☐ FH for Women ☐ Kissimmee ☐ Orlando ☐ Winter Park ☐ Winter Garden

Would you like this information mailed? ______ If yes, please enter the address you would like them mailed:

____

If picking up, requested pick-up date: ______________
In most cases, imaging reports or studies may be picked up at the facility Monday-Friday between 8:00 am - 5:00 pm.
To avoid delays we request a 24 hour notice when requesting diagnostic images/reports.

I hereby authorize Florida Hospital to release medical record information to:

Name of Person/Physician/Organization: ______________________________

Address: ______________________________ Phone: ______________

City: ______________ State: ________ Zip Code: ________ Fax: ______________

Reason for request:
☐ Continuation of Care ☐ Legal Reasons ☐ Relocation ☐ Personal Use

These Films/Reports: ☐ May be kept ☐ Must be returned

I understand I may revoke this authorization at any time by notifying Florida Hospital in writing.

I understand the revocation does not apply to information that has already been released in response to this authorization. Unless revoked, this authorization will expire twelve (12) months from the date of this authorization.

I understand that the information in my medical record may include information about my medical history, diagnoses, and/or treatment.

I authorize the disclosure of this specific information listed above. I understand that the recipient may re-disclose my medical information, and that it may no longer be protected by federal privacy laws.

Designee signature: ______________________________ Date: ______________

Patient signature: ______________________________ Date: ______________

For Radiology Use Only

Form completed by: ______________ Date: ______________ MRN: ______________

Account Number: ______________ Request completed by: ______________ Date: ______________

☐ Picked up ☐ Mailed ☐ Faxed report ☐ Sent by courier

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