



Authorization for release of information

Date ordered: _____

Date patient to pick up: _____

Date of pickup: _____

Patient: _____ File #: _____

Address: _____ DOB: _____

_____ Phone: _____

Packaged by employee: _____

I hereby give my consent to the Erie County Medical Center to release my X-rays and/or X-ray reports to the following doctor:

Given out by: _____

I understand that, pursuant to applicable state laws, the enclosed radiology films are the property of the Erie County Medical Center Corporation and must be returned to the hospital within 30 days of this date. Should the films be damaged or destroyed while in my custody, I agree not to hold the Erie County Medical Center Corporation responsible for having released the films.

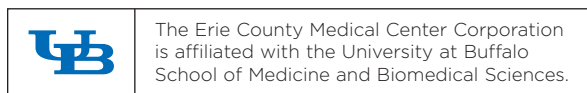
Patient signature (or responsible party): _____

Relationship (if other than patient): _____

ID checked: _____

Number of X-rays given: _____

Number of X-rays returned: _____ Date of return: _____



Rev. 5-06