REQUEST FOR PREVIOUS RADIOLOGY REPORTS AND IMAGING STUDIES

- PLEASE SEND ALL PRIOR IMAGING STUDIES ON DISC
- INCLUDE ALL REPORTS WITH IMAGES
- BREAST IMAGES MUST BE SENT IN LOSSLESS COMPRESSION

Date of Request: ___________________________

____
(Name of outside facility)

____
(Address of outside facility)

I, the undersigned, hereby authorize the release of my prior imaging studies and reports to Griffin Hospital in order to help in my diagnosis and/or treatment.

I understand that Griffin Hospital will protect my privacy in accordance with the government's rules and regulations as stated in their "Notice of Privacy" which is available upon my request.

______________________ Patient Name (print)	______________________ Date/Type of Prior Imaging Study
______________________ Patient Signature	______________________ Date of Birth

____
Patient Address (street, city, state, zip)

______________________ Patient Telephone Number	______________________ Maiden or Prior Last Name

Please send prior reports and imaging studies as requested above to:

Griffin Hospital
Radiology Department
Attention: Digital Library
130 Division Street
Derby, CT 06418
Tel. 203.732.7264
Fax 203.732.7407