Mapleton Hill Orthopaedics
AUTHORIZATION FOR X-RAY RELEASE

I authorize Mapleton Hill Orthopaedics to release the X-RAYS of:

Patient Name: ________________________________ D.O.B.___________

To: Name ________________________________ Phone _____________
Address ________________________________ Fax _____________
____

I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that this request for information could take approximately 48-72 hours to be processed.

Please release the following information:

- ☐ X-rays taken at Mapleton Hill Orthopaedics, P.C.
- ☐ ______________All films or only ______________________films.
- ☐ X-rays, other diagnostic studies brought in from other offices/x-ray locations.

I would like to request that you do NOT release information pertaining to the following:

I understand that I am taking ORIGINAL X-Rays from Mapleton Hill Orthopaedics, P.C. and it is my responsibility to return these x-rays or have them returned for me within an appropriate time frame, usually within 60-90 days. These X-Rays are part of my medical records at Mapleton Hill Orthopaedics and need to be kept at Mapleton Hill Orthopaedics.

_________________________ ______________________________________
signature of patient or guardian print patient's name

____
print guardian's name if not patient

______________________________ _________________________________
date contact phone #

This authorization expires on _____/_____/________ (Not to exceed 90 days)