



Beth Israel Deaconess  
Medical Center

AUTHORIZATION FOR RELEASE OF MEDICAL IMAGES

To Whom it May Concern:

I hereby authorize **Beth Israel Deaconess Medical Center** to release a copy of my medical imaging studies or a specified portion thereof to:

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I authorize the release with the understanding that it may include information about my medical history, my state of health or illness, and any underlying diagnoses, medical conditions and treatments as well as the findings and diagnoses related to the requested imaging studies.

Name of Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_

Medical Record Number \_\_\_-\_\_\_-\_\_\_\_\_

Medical Imaging studies requested: \_\_\_\_\_

Purpose of Request: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Print name & Relationship if other than patient

\_\_\_\_\_  
Date