5732 Canton Cove
Winter Springs, Florida 32708
Ph (407) 699-7787 Fax (407) 699-7963

MEDICAL RECORDS & FILM RELEASE FORM

Patient Request for CD & Film Pick up ☐Same Day Request ☐Telephone Request ☐Appointment Day Request

Request Date: _____ Patient Phone Number: _____

Patient Name: _____ DOB: _____/_____/_____

Specialist Name: _____ Specialty: _____

Exam Requested: ☐Mammo ☐MRI ☐CT ☐US ☐Dexa ☐X-Ray

Date of Exam(s): _____

Date & Time of Pick Up: _____@ _____AM/PM

☐Call Patient when ready ☐Mail CD ☐Mail Films **☐Need CD ☐Need FILMS**

Requested By: ☐Sue ☐Kim ☐Mari ☐Angie ☐Devon ☐Chequita ☐Kaley ☐_____

CD automatically given unless requesting physician specifies film

*****Please scan in request at Take-In and check off URGENT in eCW, but not reviewed so that is appears RED. Once this is picked up by the patient, the request will be turned black by checking off as reviewed*****

Patient consent in the form of a signature is required for all medical record records release and film release requests. By signing this form, you are releasing VinCon Diagnostic Center from responsibility of lost or missing films once they are signed out (Analog images). Please note that the ***first CD or first Set of Films per exam is provided to you at no charge***. If this request is for a reproduction of CD/Films, you will be subject to a reproduction charge of **FILM $40/exam set, CD $10 per exam and Dexa Scan $1.00 per page**. The requested film(s) or CD will *need to be picked up within 7 business days* or it will be destroyed and the reproduction charge will be applied for the next requested copy.

☐ Signing out all prior images from Analog Film Storage. Patient acknowledges that these images cannot be replicated due to Analog technology. Patient assumes all responsibility for the storage of their images. **Patient Initials_____**

☐ I decline to take my Analog films with me today. I give VinCon permission to destroy all of my analog films as they are no longer storing Analog film. I understand that once Analog films are destroyed they can never be reproduced.
Patient Initials_____

Patient Signature _____ **Today's Date**_____

Print Patient Name _____ **Date of Birth** _____

Guardian Signature _____ **Today's Date** _____

Other Authorized Signature _____ **Today's Date** _____

Relation: _____ **☐Release received if other than patient** **☐Verified auth on HIPAA form on file**

VinCon Staff Witness _____ **Today's Date** _____

OSF Received: ☐MRI ☐CT ☐US ☐XRAY MAMMO
Date: _____ ☐Comparison Done
Patient Signature _____

OSF Picked up: ☐MRI ☐CT ☐US ☐XRAY MAMMO
Date: _____
Patient Signature _____