

PATIENT CONSENT FOR WAKE RADIOLOGY UNC REX HEALTHCARE TO RELEASE IMAGES**Confidentiality Notice**

The information contained herein is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by telephone and destroy all copies of the original message.

STEP 1 - PATIENT TO COMPLETE

By signing below I give consent to Wake Radiology to release any imaging and/or information regarding my medical history, symptoms, treatment, examination results or diagnosis for continuing medical care.

Patient Name (print) _____ Date of Birth _____
 Previous Name, if applicable _____ Last 4 digits of SSN _____ Phone number () _____
 Patient / Guardian Signature _____ Date _____
 Specify exam(s) or body part imaged _____

STEP 2 - PATIENT TO INDICATE WHERE IMAGES & REPORTS ARE TO BE SENT

To me

Mailing Address _____
 City _____ State _____ Zip Code _____

To the Medical Provider / Facility listed below

Provider Name _____
 Practice or Hospital Name _____
 Mailing Address _____
 City _____ State _____ Zip Code _____
 Appointment Date (if one has already been scheduled) _____

STEP 3 - PATIENT TO FAX TO WAKE RADIOLOGY

Please fax the signed consent form to Wake Radiology at 919-859-0182. Images and reports will be sent 24-48 hours after request has been received.

➔ The patient is responsible for ensuring that the mailing address provided in section 2 is accurate. Incorrect information can cause significant delays due to returned / lost mail.