PATIENT CONSENT FOR WAKE RADIOLOGY UNC REX HEALTHCARE TO RELEASE IMAGES

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.