PATIENT CONSENT FOR WAKE RADIOLOGY TO RELEASE IMAGES

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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 __________

Social Security Number ______-______-________ Phone number ( ) ____________________

Patient / Guardian Signature ____________________ Date__________

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.*