



CHRISTIANA CARE

# FILM / CD / REPORT RELEASE FORM

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

Date of Birth: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

Date/Type of Procedure: \_\_\_\_\_

***Please circle Medical Record to be picked up: Film CD Report***

***I hereby authorize Christiana Care Imaging Services to release/and or give copies of my medical records to:***

\_\_\_\_\_  
*(Name of Person picking up medical records)*

\_\_\_\_\_  
*(Date medical records to be picked up)*

\_\_\_\_\_  
*(Patient's Phone Number)*

***\*If needed for legal consultation, we must have authorization from the patient prior to releasing medical record***

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Person Picking Up Medical Records

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date