

THE STAMFORD HOSPITAL  
DEPARTMENT OF RADIOLOGY  
30 SHELBURNE ROAD  
STAMFORD, CT 06904-9317  
(203) 276-7863  
(203) 276-5967 - Fax

RELEASE OF RADIOLOGY FILMS/REPORTS/CDs

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Telephone #: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Date of Films: \_\_\_\_\_ Type of Films: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**The requested films were taken at:**

\_\_\_\_\_ The Stamford Hospital  
\_\_\_\_\_ Darien Diagnostic Imaging Center  
\_\_\_\_\_ St. Joseph Medical Center  
\_\_\_\_\_ Tully Center Diagnostic Imaging Center  
\_\_\_\_\_ Strawberry Hill Diagnostic Imaging Center  
\_\_\_\_\_ Other: *name* \_\_\_\_\_

**Please release a copy of the films/reports/cds detailed above to:**

\_\_\_\_\_ me, the patient (*name and address above*)  
\_\_\_\_\_ other : *name* \_\_\_\_\_  
*address* \_\_\_\_\_  
\_\_\_\_\_  
*city/state/zip* \_\_\_\_\_

\_\_\_\_\_ Permission documentation provided from patient, if other than patient.

This authorization shall expire 30 days from the date appearing below.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*(patient's signature)*

Witness: \_\_\_\_\_ Date: \_\_\_\_\_  
*(file room staff)*

If person signing is not the patient, indicate relationship to patient: \_\_\_\_\_