



Request for Release of Information

Patient Name: _____

DOB: _____

I am requesting a copy of the radiology report for my (exam) _____
_____, dated _____, to be released directly to me.

I understand the department/hospital is required by New York State, Department of Health, Public Health Law Code, Section 18 to notify the ordering physician of this Request prior to releasing the report.

Patient Signature: _____ **Date:** _____

Clerk Signature: _____ **Date:** _____

Department Use ONLY

Notification:

Medical Record No.: _____

Ordering Physician: _____ **Date:** _____

Radiologist: _____ **Date:** _____

Fax to: (212) 774-2327