RADIOLOGY ASSOCIATES of HARTFORD, P.C.

Avon • 35 Nod Road
Bloomfield • 673 Cottage Grove Road
Enfield • 9 Cranbrook Blvd
Glastonbury • 31 Sycamore Street
Rocky Hill • 476 Cromwell Avenue

Phone: (860) 969-6400
Fax: (860) 969-6392

Film Record Release

RECIPIENT Information	*SENDER Information*
Attention to:	**From:** ☐ **Avon** 35 Nod Road, Suite 101 • Avon, CT 06001 ☐ **Bloomfield** 673 Cottage Grove Road • Bloomfield, CT 060021 ☐ **Enfield** 9 Cranbrook Boulevard, Suite 102 • Enfield, CT 06082 ☐ **Glastonbury** 31 Sycamore Street, Suite 102 • Glastonbury, CT 06033 ☐ **Rocky Hill** 476 Cromwell Avenue • Rocky Hill, CT 06067
DATE OF REQUEST: **FAX #:**	**PATIENT INFORMATION:** Name: _____ DOB: _____ Study: _____

Please send requested information to the RAH location identified above.

FDA MQSA regulation 21 CFR 900.12 (4) states that each facility that performs mammograms: (ii) Shall upon request by, or on behalf of, the patient permanently or temporarily transfer the original mammograms and copies of patient's reports to a medical institution, or to a physician or health care provider of the patient, or to the patient directly.

☐ I hereby request permission to have my x-rays released to the above. I am aware that these films are part of my permanent record and it is my responsibility to return them within 30 days.

☐ I request and authorize Radiology Associates of Hartford, P.C. to release my _____

To: _____

I realize these are part of my permanent office record and do hereby relieve Radiology Associates of Hartford, P.C. of the responsibility for the images return of the permanent office file.

Patient Signature: _____ **Date:** _____

Employee Signature: _____ **Date:** _____

Please telephone (name) _____ at (number) _____ if this document is misdirected or incomplete.

****Confidentiality Notice****

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