



RADIOLOGY
ASSOCIATES
TALLAHASSEE



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Medical Records Release Form

Patient Information

Patient Name: _____ Date of Birth: _____

Records Requested

- ☐ Radiology Reports Only
☐ Images Only
☐ Radiology Reports and Images

Exams Requested:

Delivery Method

- ☐ Pick Up
☐ Electronic Copy (PowerShare)
☐ Mailed Copy

Address: _____

- ☐ Mail to Other Facility

Facility Name: _____ Physician: _____

Address: _____

Authorization to Disclose

- ☐ I authorize the individual listed below to pick up my medical records on my behalf.

Name: _____

Relationship to Patient: _____

- ☐ Radiology Reports Only
☐ Images Only
☐ Radiology Reports and Images

Authorization & Signature

- I am requesting access to my own medical records and authorize Radiology Associates of Tallahassee to release the records identified above.
- I understand that identification will be required before records are released.
- I understand that email transmission may not be secure and accept any associated risks if I request records by email.

Signature: _____ Date: _____

Print Name: _____