Name:
DOB:
MRN:
PCP
Patient ID/Label

UCSF Medical Center

INTERSTITIAL LUNG DISEASE PROGRAM **RADIOLOGY RELEASE FORM**

Dear Patient:

Give this form to the radiology department, in order to pick up your CT scans to bring with you to your appointment.

To: ______________________________

Name of physician or institution

____

Street address **City** **State** **Zip Code**

I am requesting and authorizing you to release and furnish medical records and information to:

UCSF Interstitial Lung Disease Program
400 Parnassus Ave., Room 591, Box 0359
San Francisco, CA 94143
tele: (415) 353–8764 | fax: (415) 353–8944

The requested records and information pertain to:

______________________________ ______________

Patient/client name **Date of Birth**

This authorization shall become effective immediately and shall remain in effect until ______________.
Date

This authorization is limited to the following records and information:

- **Chest X-ray reports**
- **Chest High Resolution CT reports**
- **All films of the chest (CXR or Chest CT scans)**

The receiver may use the medical records and information authorized only for the purpose of interstitial lung disease diagnosis, treatment or other pulmonary problems.

I understand that the receiving party may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I understand that I have a right to a copy of this authorization upon my request.

__________ ______________________________ ______________

Date Signed **Signature of patient/client/parent/guardian/conservator** **Relationship if not patient/client**

☐ **Interpreter Used**

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Witness signature (required if patient/client/representative is signing by mark)