DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

The Saratoga Hospital

Medical Imaging Consent to Release Record

PATIENT INFORMATION	
Patient's Last Name:	Patient's First Name:
Birth Date:	Imaging to send: ☐ CT ☐ MRI ☐ XR ☐ Other: _____ Date of Exam: _____
Email Address:	

ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I authorize this facility to use RadConnect to share my radiology images with me in lieu of burning a CD. I understand that my images will be stored in RadConnect for 60 days at no cost to me. During that time, I understand I have the option to purchase permanent archival directly from RadConnect.

_____ _____
Patient/Guardian Signature Date/Time

_____
Relationship to Patient

_____ _____
Signature of Witness Date/Time

********** SARATOGA HOSPITAL MEDICAL IMAGING DEPARTMENT USE ONLY **********

☐ Hold ☐ Send

_____ _____
Signature of Staff Disclosing Information/Title Date/Time Completed

☐ Photo ID verified – Initials: _____ Medical Record Number: _____

Please see Patient User Card for information on receiving your radiology images from RadConnect.

Additional information can be found at www.RadConnect.com