CAL POLY
Health Services/California Polytechnic State University
San Luis Obispo, CA 93407-0210
Office (805) 756-1211 Radiology Fax (805) 756-5223

Please print. Must be completed in ink

Authorization for the release of ORIGINAL x-ray studies

Patient Name: _____ Date of Birth: _____
Cal Poly Empl ID #: _____ Telephone: _____
Address: _____

I authorize Cal Poly Health Services to release:
☐ Original X-ray film(s) ☐ Radiology report(s) to:

Name: _____Telephone: _____
Street Address: _____ _____FAX: _____
City, State, Zip Code: _____

- ***Reason for release of information:***

☐ Insurance ☐ Transfer of care ☐ Personal File
☐ Moving out of area ☐ Specialist consult ☐ Legal ☐ Other _____

Consent
This information is intended for use by the above named recipient only. I am aware that the x-rays released are originals and that I am responsible for returning these films. In the event that they are not returned, I understand that the x-rays will no longer be part of the patient record and any future requests for the x-rays cannot be processed. By signing below, I agree and understand all of the above. This authorization will expire exactly one year from the date below or on _____. I have the right to receive a copy of this authorization. I may revoke this authorization at any time in writing. I understand that information used or disclosed under this authorization may be subject to redisclosure by the recipient without being further protected. Incomplete information may cause a delay.

Copy of a valid picture I.D., including signature, must be included with all mailed and/or FAXed requests.

Patient Signature: _____ Date: _____

Please allow 15 days for processing. Health Services Policy on the Release of Medical Records is posted in Health Center. Copy available upon request.

Revised 9/28/12