Radiology Associates of Venice and Englewood

Records Request for Continuum of Care

Patient Information:

Name: _____ DOB: _____

Authorizes:

Radiology Associates of Venice and Englewood – Medical Records
512 Nokomis Avenue South, Venice, FL 34285
Phone: (941) 488-7781 | Fax: (941) 488-0791

To request records from:

Facility Name: _____

Facility Address: _____

Facility Phone #: _____ Facility Fax #: _____

Imaging Studies & Corresponding Reports Requested:

☐ Breast (ALL, entire breast imaging history) ☐ Abdomen/Pelvis ☐ Chest ☐ Head/Brain

☐ Other_____

Comments: _____

Transfer Method Note: USB Flash drives are **Not** accepted.

☐ Nuance PowerShare Preferred ** Radiology Associates of Venice and Englewood -RAVE

☐ CD

* Please FAX all reports to (941) 488-0791

Authorization:

I authorize the release of my confidential health information as described. I understand that I may revoke this authorization at any time in writing, except where action has already been taken in reliance on it. I acknowledge that this authorization will expire twelve (12) months from the date of signing unless a sooner date is specified here: _____.

Signature: _____ **Date**: _____

To comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the U.S. Health and Human Services Mammography Compliance Act of 1992, mammography providers must transfer original films/CDs and reports upon patient request. RAVE understands responsibility for the proper use and confidentiality of the health care information required, such as treatment records, testing, and result information.