



CONSENT FOR RELEASE OF MEDICAL INFORMATION

eRAD, Inc. provided radiology imaging services to Pascack Valley Hospital. As a result of the Hospital's closing, eRAD has possession of selected digital radiology images and reports.

To obtain these materials, please execute this form and fax, mail, or email (actual signature required) to customerrequest@erad.com back to eRAD together with indicated payment. The images and reports will be provided on a CD per study basis.

Patient Name _____ Social Security No. _____
Date of Birth _____ Requested study date _____ Procedure Type _____
Patient Address _____ Telephone No. _____

I _____, do hereby consent to and authorize eRAD, Inc. to disclose my private health information to the following persons:

Name of Person, Doctor, Hospital, etc. _____

Attention _____

Address _____

For the purpose of ("treatment" "payment") _____

I understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon and that this consent will remain in force in order to effectuate the purposes for which it is given.

Dated this _____ day of _____, 20_____

Consent expires the _____ day of _____, 20_____

PATIENT SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/LEGAL GUARDIAN/AUTHORIZED REPRESENTATIVE (circle one)
WITNESS _____

Please enter the required information, sign this form and return it with a check made out to "eRAD, Inc" or include credit card information below in the amount of \$_____

Credit Card # _____ Type _____ Exp. Date _____ Security ID _____
Name on the Card _____

Processing and delivery charges for images:
USPS \$40
FedEx 2 Day \$52
FedEx Overnight \$63

Processing and delivery charges for reports:
USPS \$10
FedEx 2 Day \$22
FedEx Overnight \$33

**NOTE: Additional studies of same patient at the time of original request \$10

FOR OFFICE USE ONLY

Received _____ ID Confirmed _____ Completed _____
Initial Date Initial Date Initial Date