DIE RADIOLOGEN
GEMEINSCHAFTSPRAXIS BETZDORF

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Authorization for Release of Medical Records

Name: _____

Date of birth: _____

I release all the doctors of the Radiologische Gemeinschaftspraxis Betzdorf, entrusted with my medical data and personal data, of their medical confidentiality towards mentioned below doctors or hospitals.

Precisely I allow the Radiologischen Gemeinschaftspraxis:

■ The sending of my finding reports or other data as hard copy (post, fax) if they are required for therapies or diagnosis.

■ To provide information of my finding reports or other data by phone, if they are required for following therapies or diagnosis

■ To post my examination images as CD

To which Doctor/ Hospital we are allowed to provide information ?

1. Doctor / Hospital:

Name:_____

Address:_____

2. Doctor/Hospital:

Name:_____

Address:_____

Date Signature

This declaration is valid until your notice of revocation.