KONA
COMMUNITY HOSPITAL
Care You Can Count On

CONSENT TO RELEASE RADIOGRAPHS

I hereby authorize Kona Community Radiology Department to release information regarding:

Patient Name: _____ D.O.B.: _____

Address: _____ Phone: _____

☐ **RADIOLOGY RADIOGRAPHS**

The radiographs that are provided to you are the ORIGINALS and are a part of our records and are the property of Kona Community Hospital Radiology Department. The radiographs must be interpreted by the radiologist before they can be released.

YOU ARE RESPONSIBLE FOR RETURNING ALL RADIOGRAPHS BORROWED WITHIN 30 DAYS. WE ARE LEGALLY REPONSBIBLE FOR THIS PERMANENT RECORD.

I understand the information will be released to Dr. _____

PATIENT SIGNATURE: _____ **Date:** _____

WITNESS: _____

RELATION TO PATIENT: _____

X-RAY JACKET NUMBER: _____

RADIOGRAPHS OF: _____

NUMBER OF RADIOGRAPHS: _____ **Date of exam(s):** _____

DATE RADIOGRAPHS RELEASED: _____

☐ **RADIOGRAPHS FROM PACS INCLUDING CDs**

The radiology films and or CD that are provided to you are *copies* of the originals.
The originals are the property of Kona Community Hospital Radiology Department.
THESE ARE COPIES AND DO *NOT* HAVE TO BE RETURNED.

DATE OF EXAM: _____ **EXAM** _____

Identity of authorized signer verified by: ☐ **State I.D.** ☐ **Driver's License** ☐ **Other**
Documentation of authorization as "designated patient representative" _____
Copy of documentation obtained for permanent record ☐ **YES** ☐ **NO**

The Imaging Center
Kona Community Hospital
79-1019 Haukapila Street
Kealakekua, Hawai'i 96750
(808) 322-4423
(808) 322-4576 Fax

PLEASE SCAN THIS COMPLETED DOCUMENT INTO THE PATIENT'S FILE *