NYU Langone | FERTILITY MEDICAL CENTER | CENTER

Authorization for Release of Surgical/HSG Film(s) to Patient

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I, or my authorized representative, request(s) that radiology film(s) regarding my care at NYU Fertility Center (NYUFC) be released to me. I am removing ORIGINAL film(s) from the NYUFC and it is my responsibility to return these film(s) or have them returned for me within an appropriate time frame. These film(s) are part of my medical record at the NYUFC. Once removed, these film(s) are my responsibility and NYUFC cannot be held liable for their loss or damage.

_____ _____/ _____/ _____ _____

Name of Patient (Please print) ***Date of Birth*** ***Last 4 Digits of SSN***

Name, address and telephone number of the person you are designating to receive information:

_____

Please release the following information:

☐ HSG Film(s) performed on _____/ _____/ _____.

☐ Film(s) from surgery on ____/ _____/ ____.

☐ X-rays, other diagnostic studies brought in from other offices/x-ray locations.

Reason for release of information:

_____

I understand that this request will be fulfilled within 10 days.

_____ _____

Signature of Patient or Authorized Representative ***Date***

_____

Relationship of Representative