Parkway Radiology

❑ PEH ❑ MEH ❑ MNH ❑ GEH ❑ MRA

AUTHORISATION FOR RELEASE OF INFORMATION

I , _____, of Medical Record Number _____ ,
(Name of Patient) (MRN)

hereby authorize Parkway Radiology to release the Films/ Soft Copy Images / Reports*

of my radiological study:

Name of Procedure(s): _____ performed on: _____
(e.g. MRI-CHEST) (Date)

to the following party:

Doctor Name: _____

Clinic Address: _____

_____

_____
Signature of Patient

_____ _____
Name of Patient Date

**Delete as appropriate*

The signatory of the Authorisation for release of information shall be:

a) The patient himself/herself if he/she is 21 years of age and above and is of sound mind.
b) The parent or lawful guardian if the patient is below 21 years of age
c) The committee of person or estate appointed under the Mental Disorders & Treatment Act(Cap 178) in the case of a patient who is of unsound mind.