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Frederick Flynt, M.D.
Gustavo Westin, M.D., M.P.H.
Kuang S. "Aaron" Chang, M.D.

3320 Old Jefferson Rd | Bldg. 700 | Athens, GA 30607 |Phone: 706-353-2990 | Fax: 706-353-2992 | universitycancer.com

[PATIENT INFORMATION]

Patient Name:		DOB:		SSN (Last 4 Only)	XXX – XX -

(A) ❑ I authorize **UCBC TO RELEASE MY IMAGING TO** the recipient below for continuation of my care.

(B) ❑ I request imaging from the entity listed below **TO BE RELEASED TO UCBC** for continuation of my care.

(C) ❑ I authorize **UCBC TO RELEASE MY FILMS TO ME** for purposes of my continued care.

(A) Release Imaging to **OR** (B) Request Imaging From:		
Facility/Physician Name:		
Address:	City	State/Zip
Phone:	Fax:	

[IMAGING REQUESTED]

Release from UCBC: ❑ CT Scan (In-house imaging only – we **DO NOT** release outside images)

Request From Outside Facility: ❑ CT ❑ MRI ❑ PET ❑ Mammogram

Dates of Service Requested: ❑ Most Recent ❑ Date:_______________ ❑ Other:_______________

Please send all requested images in DICOM format using the address and FedEx Account number below

University Cancer & Blood Center Prior Imaging Requests 3320 Old Jefferson Road|Building 700 Athens, Georgia 30607	**FedEx Account #: 122669831** Please send **STANDARD OVERNIGHT**, unless otherwise noted. If you are unable to send the requested imaging or you have questions please call (706) 353-2990 and ask to speak with Melissa or Wes.

By signing below, I acknowledge that: I may revoke this authorization in writing, but it will not affect disclosures/transfers already in progress made with this authorization

- I may refuse to sign this authorization, and my treatment may not be conditioned on my signing of this form, unless the purpose of my treatment is disclosure to a third party (for example, a drug test for employment)
- I can receive a copy of this authorization upon request
- A photocopy or scanned image of this authorization may be used in lieu of the original
- I understand that recipients may not be subject to federal law and disclose information which I have authorized them to receive

Signature:____ Date:_________________________

Patient or Authorized Representative

If signed by a personal representative of patient, print name and relationship to patient:	
Name:	Relationship:

Please attach a copy of documentation of personal representation, e.g., Power of Attorney, Legal Guardianship.