Release of Information to Charter Radiology

Telephone- 443.917.2855 Fax- 410.346.5775

Name: _____

Date of Birth: _____ Type of Procedure:_____

Name of Hospital or Clinic:_____

Please mail films/CD and reports to:
Charter Radiology
10700 Charter Drive Suite 110
Columbia, MD | 21044

I hereby authorize the release of films and/or medical records regarding the continuity of care to Charter Radiology.

_____ _____
Patient Date

_____ _____
Charter Radiology Representative Date