HAWSE HEALTH CENTER **PO BOX 97** **BAKER, WEST VIRGINIA 26801** **PHONE: (304) 897-5915** **FAX: (304) 897-5917**	**OUT BEFORE READ? ☐** **(If yes, please attach charge to this release.)**
PATIENT NAME:	**RELEASED TO: PATIENT ☐ PHYSICIAN ☐**
DATE OF BIRTH:	**ADDRESS:**
MEDICAL RECORDS #:	
TYPE OF FILMS:	
DATE OF FILMS:	
DATE RELEASED:	**DATE RETURNED:**
I authorize Hawse Health Center Radiology to release my radiographs/reports. I agree to return the above mentioned films to the HHC Radiology within 30 days. I release the health center, its employees and all other persons caring for my at the health center from any liability connected with the use of these records or information in them by anyone outside the health center.	
SIGNATURE:	**DATE:**
RELATIONSHIP TO PATIENT:	**WITNESS:**
COMMENTS:	

Zip6B:\Radiograph.Report release 02.04