# How to Access Your Radiology Images

It's never been easier to access your images. If you want to view your images and reports, we have two places for your convenience. Please view through MyVHC, your patient portal. Additionally, you have access through PowerShare.

To obtain your images in person or by mail, please bring the form on the second page of this flier and visit VHC Health, Zone B, Image Film Room, or mail it to 1701 N. George Mason Drive, Arlington, VA 22205, Attention Image Library. Please call 703.558.6298 with questions.

## WHAT IS POWERSHARE?

PowerShare is a secure image-sharing application that allows patients and referring providers to easily upload and share their images. PowerShare is efficient and easy to use.

## WHY POWERSHARE?

VHC Health now makes it easy for you to share or request a copy of your images electronically or securely upload your medical images to PowerShare™. Once you set up a PowerShare account, you can:

- Gain access to the images you have requested VHC Health to upload to your PowerShare account
- Access your images from anywhere, at any time, with any device
- Upload and share non-VHC Health image studies with VHC Health
- Share your images with doctors and specialists as needed
- Upload past exams from personal CDs to your account
- Your privacy is protected. When using your account, all Internet communication between your web browser and the PowerShare network is encrypted to make sure that no one can see your medical information. This information will never be disclosed or used without your consent.
- Your medical records are never accessible to anyone except the people you have specified. The access you grant to others can be revoked at any time.

To log in or register as a new user to PowerShare:
https://www1.nuancepowershare.com/smr/login

**Thank you for choosing VHC Health for your care.**

SEE FORM ON PAGE 2 ▶

**Department of Medical Imaging**
**Phone: 703-558-6298 FAX: 703-558-5908**

X-RAY Number _______________

(1) ____________________ **Patient's Name at Time of Treatment**

(2) ____________________ **Date of Birth**

(3) ____________________ **Street Address**

(4) ____________________ **Home Phone Number**

____________________ **City** **State** **Zip Code**

____________________ **Work Phone**

(5) The undersigned hereby authorizes and requests Virginia Hospital Center to provide access to my medical record for the purpose of: ☐ **Continued Medical Care** ☐ **Personal** ☐ **Legal** ☐ **Other:** ____________________. Provide records by means of: ☐ **Mail** ☐ **Fax*** **Records will only be faxed to physician offices, hospitals, or other treatment facilities. Items listed in #9 and #10 will not be faxed.**

(6) ____________________
**Identity of third party or name of any duly authorized representative** (name of person to send your records to)

____________________
**Street Address** **City** **State** **Zip Code**

The foregoing is subject to such limitations as indicated below:

(7) Covering records for the period from: ____________ to ____________.
**Date** **Date**

(8) Confined to the following specified information: Please check what information is needed.
**NEW ELECTRONIC PROCESS - FOR RECEIVING YOUR IMAGES - THROUGH NUANCE POWERSHARE NETWORK**
**Please send the records I indicated above through an electronic delivery option (clearly provide the following information):**

☐ Email address: ____________________-specific study________ OR

☐ MAIL specific study ____________________ *via/* ☐ *CD* *include* ☐ *REPORT*

(9) **IN ACCORDANCE WITH FEDERAL REGULATION (42 CFR PART 2)**

I hereby consent to the release of any and all records for the treatment of alcohol or drug use.

(10) I hereby authorize Virginia Hospital Center to release to the above named source the following information for the period(s) identified above: All medical records or other information regarding my treatment, including treatment or evaluation for psychiatric and/or HIV/AIDS conditions.

(11) I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Health Information Management Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ____________________ .
If I fail to specify an expiration date, event, or condition this authorization will expire 1 year from the date signed.

(12) I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment I understand that I may inspect the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the AVP Clinical Revenue Integrity at 703-558-6116.
Virginia Hospital Center is not responsible for any re-disclosure of the information provided.

(13) I understand that there may be a charge for searching, handling, maintaining, reviewing, and preparing copies in accordance with 8.01-413 of the Code of Virginia.

(14) ____________________ **Date**

(15) ____________________ **Signature of Patient**

(16) ____________________ **Witness**

(17) ____________________ **Signature of Legal Representative**

**DEPARTMENT OF MEDICAL IMAGING AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION**



122206-7280-061923

Patient Label