THE AMERICAN REGISTRY OF RADIOLOGIC TECHNOLOGISTS®

AUTHORIZATION FOR RELEASE OF INFORMATION

INSTRUCTIONS

This form authorizes ARRT to release information about you to employers, staffing agencies, and other organizations.

1. Print this document.
2. Complete all fields in the form:
    a. Legibly print the name of the person and organization to whom you'd like us to send information.
    b. Specify the number of days for which you authorize this release to be valid.
    c. Sign and print your legal name. Date the form and include your ARRT identification number.
3. Complete all fields in the fax cover sheet:
    a. Your name, ARRT ID, date
    b. The type of information you'd like us to send
    c. To whom you'd like us to send the information, their organization and contact information
4. Fax the cover sheet and completed form to 651.681.3297.

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OF RADIOLOGIC
TECHNOLOGISTS®

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As an inducement to The American Registry of Radiologic Technologists (ARRT) and its Trustees, officers, employees, representatives and agents, and each and all of them (collectively, its "agents") to provide information about me freely, fully, and openly to

_____ of _____
(Individual's Name) (Organization's Name)

I hereby request and authorize the ARRT to provide full information concerning me and my interactions with the ARRT including information regarding my education, training, employment, professional and academic performance, and any disciplinary matters. I understand and agree that in no event will the ARRT release any of my examination papers, or any questions or answers on any examination administered by the ARRT.

I agree to waive and release, indemnify, and hold harmless ARRT and each and all of its agents who provide any such information concerning me from, against, and with respect to any and all claims, losses, expenses, damages, liabilities, and judgments of any and every kind or nature whatsoever that arise, or are alleged to have arisen, from, out of, with respect to, or in connection with the provision of any such information about me.

I understand and agree that this AUTHORIZATION FOR RELEASE OF INFORMATION is valid for a period of _____ days from the date of my signature below.

This AUTHORIZATION FOR RELEASE OF INFORMATION may be signed by me in multiple counterparts, and, if it is, each such counterpart shall constitute a signed original. My signature on a carbon copy, facsimile copy, scanned copy, pdf file, or other reproduction of this document shall be as valid and binding as a signed original.

Signature: _____

Printed Name: _____

Date: _____, 20_____

ARRT ID #: _____

FAX COVER SHEET

ATTENTION: Authorization for Release of Information American Registry of Radiologic Technologist. FAX ARRT at 651.681.3297

FROM: _____ ARRT ID # _____

DATE: _____ NUMBER OF PAGES (including cover sheet): _____

WHAT TYPE OF INFORMATION DO YOU WANT US TO SEND?

☐ Disciplinary Action Information

☐ Other (please specify): _____

TO WHOM DO YOU WANT US TO SEND THE INFORMATION?

INDIVIDUAL'S NAME: _____

ORGANIZATION NAME: _____

MAILING ADDRESS: _____

_____

TELEPHONE: _____ FAX: _____

This transmission may contain material that is CONFIDENTIAL under federal and state statutes and is intended to be delivered to only the named addressee. Unauthorized use of this information may be a violation of criminal statutes. If this information is received by anyone other than the named addressee, the recipient shall immediately notify the sender at the address or the telephone number above and obtain instruction as to the disposal thereof. Under no circumstances shall this material be shared, retained, or copied by anyone other than the named addressee.