HDI
High Desert Imaging

Request for an Individual's Health Information

Last:	First:	Middle:
Other Names used:	Date of Birth:	SS#
Address:		
Home Phone:		Work Phone:

I hereby request access to the protected health information in my health record from (date)_____to (date)_____ maintained or created by High Desert Imaging listed below

- ☐ All Medical Records
- ☐ Billing Records
- ☐ Lab Reports
- ☐ CD / Films (Please circle one)
- ☐ Imaging Reports (Body Part)_____
- ☐ Other_____

☐ I will pick up copies of my records ☐ Mail/Fax (Please circle one) copies of my records to individual listed below

Records From:	Records To:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of request: _____Patients request, ____for outside comparison Images, ____referral, ____ other

I understand:

- I may revoke this authorization at any time by providing my written revocation to: HDI 976 Mountain City Hwy, Elko NV 89801. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected my federal privacy regulations
- **The information authorized for release may include information which may indicate the presence of a communicable disease or noncommunicable disease.**

_____ _____ _____

Signature of Patient, Parent, or Legally Authorized Representative **Relationship to Patient** **Date**