



## 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

- |   |   |
|---|---|
| <input type="checkbox"/> All Medical Records  | <input type="checkbox"/> Billing Records                |
| <input type="checkbox"/> Lab Reports  | <input type="checkbox"/> CD / Films (Please circle one) |
| <input type="checkbox"/> Imaging Reports (Body Part) _____  | <input type="checkbox"/> Other _____                    |
| <input type="checkbox"/> I will pick up copies of my records  |   |
| <input type="checkbox"/> 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