Image & Report Request Form

I, ____, request that Desert Radiology provide me with copies of my medical records as listed below. I also understand that this request will be kept on file, but that the request is only valid for the records specified below and expires once this request is processed.

Patient Name: ____ **DOB**: _____________________

Address: ____

City, State, Zip: ____

Home Phone: _________________________________ **Cell Phone:** _________________________________

RECORDS REQUESTED:

☐ **CD (Images & Report)** ☐ **REPORT Only**

Exam(s) Requested: ____

Date(s) of Service: ____

DELIVERY INSTRUCTIONS:

☐ Mail to the address provided above ☐ Send to my healthcare provider

Name & address of healthcare provider: ____

____

I, the undersigned, certify that I am the patient named above, or a representative of the patient to whom legal authorization has been given to obtain the information requested. I also understand that the obtaining and/or use of an individual's personal health information under pretenses is a criminal offense and punishable by law.

____ ________________________

Signature of Patient or Legal Guardian Date

____ ____

Printed Name of Legal Guardian Relationship to Patient

Please fax completed form to: 702-794-2104 or email to filerooms@desertrad.com