



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 Report & Images REPORT Only

Exam(s) Requested: _____

Date(s) of Service: _____

DELIVERY INSTRUCTIONS:

I will pick up (Photo ID required) Authorized representative will pick up (Photo ID required)

Mail to the address provided above

Name of authorized representative: _____

REQUESTED Pickup Location:

Cathedral Rock Centra Point Eastern Horizon Ridge Nellis

Palomino Pahrump St. Rose Wynn

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