Reno Diagnostic Centers

Records Release Form

Last Updated: July 24, 2015

I, ______________________________________, request that Reno Diagnostic Centers provide me or any persons designated below with copies of my Protected Health Information (PHI) as listed below. I understand that there may be processing fees involved and that I will be advised of the applicable fees (if any) prior to the processing of my request. 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.

Date of Birth: ________________________ SSN: ____________________ MRN: __________________________

Mailing Address: ____
(Street) (Apt / Box No.) (City, State, Zip)

Home Phone: _____________________________ ____________ Work Phone: __________________ _______________________

RECORDS REQUESTED:

☐ All Exams ☐ Specific Exams:

Exam Date	Exam Type	Report / Images
___________	____________________________	☐ Report ☐ Images ☐ Billing Statements
___________	____________________________	☐ Report ☐ Images ☐ Billing Statements
___________	____________________________	☐ Report ☐ Images ☐ Billing Statements
___________	____________________________	☐ Report ☐ Images ☐ Billing Statements

☐ Clinical Health Record (please note, can only be sent via email; please specify email address)

Email: ____

IMAGING PREFERENCE: ☐ CD-ROM ☐ Paper and/or Film

ACCESSING/DELIVERY INSTRUCTIONS:

☐ I will pick up (Photo ID required)

☐ An authorized representative can access. (photo ID required)

Name of authorized representative: ____

☐ Mail me at the mailing address above

☐ Send to Physician:

☐ Mail (fill out address below) ☐ Fax (fill out Physician's name and fax number below) ☐ Both (fill out all below)

Name (use doctor's name if sending to medical facility): ____

Address: ____
(Street) (Apt / Box No.) (City, State, Zip)

Phone No.: ______________________________________ Fax No.: ____

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 false pretenses is a criminal offense and punishable by law.

____ ___________________ ______________________________

Signature of Patient or Legal Guardian **Date** **Relationship to Patient**