IOWA RADIOLOGY
REQUEST TO SEND PROTECTED HEALTH INFORMATION
_____TO OTHERS ___X_____TO SELF

As a patient of Iowa Radiology, you are entitled under federal law to request your personal protected health information for yourself or provided to another individual. Please complete this form and submit it to **medrecords@iowarad.com** or via fax at (515) 226-9812 along with a copy of a valid, state-issued photo ID. Once received, the information will be used to verify your identity and your request will be processed.

Patient Name: _____ **Birth date:** _____

Patient Phone Number: _____

Date of service: _____**Type of service:** ☐**X-ray** ☐**CT** ☐**US** ☐**MRI of**_____

Information requested: Report: _____ **Images via USPS (IMAGES MAY NOT BE EMAILED):**_____

I would like Iowa Radiology to send the copy(ies) imaging reports via EMAIL to:

_____

PRINT e-mail address of individual

I would like Iowa Radiology to SEND VIA USPS, a disk with requested images to:

_____

PRINT Address, city state zip to mail disk

I will PICK UP at Iowa Radiology Clive / Downtown / Ankeny: circle one

I understand the revocation will not apply to information that has already been released in response to this authorization.

I understand that Iowa Radiology is given thirty days to process my request for access.

This authorization will expire one year from the date of signature.

By signing below, I acknowledge and agree to the above conditions.

_____ _____

Signature of Patient **Date**

_____ _____

Medical Records Signature Date request fulfilled.

Receipt of Reports/Images:

_____

Signature of Patient/Authorized Party Date: