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. 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 imaging report copies 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: