



Phone: 775.753-9431 | Fax: 775.778.9469

I, \_\_\_\_\_, request that Elko Diagnostic Imaging provide me with copies of my medical records 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.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
(Optional)

RECORDS REQUESTED:

- All Exams
 Specific Exams:

Table with 3 columns: Exam Date, Exam Type, Report / Images. Includes checkboxes for Report and Images for each row.

DELIVERY INSTRUCTIONS:

- I will pick up (Photo ID required)
 CD-ROM  Paper and/or Film
 An authorized representative will pick up. (photo ID required)
Name of authorized representative: \_\_\_\_\_
 CD-ROM  Paper and/or Film
 Mail me at the address above
 CD-ROM  Paper and/or Film
 Send to Physician:
 Mail (fill out address below)  Fax (fill out Physician's name and fax number below)  Both (fill out all below)
 CD-ROM  Paper and/or Film

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 pretenses is a criminal offense and punishable by law.

Signature of Patient or Legal Guardian Date Relationship to Patient