TRISTATE RADIOLOGY CENTER
1510 Wagon Wheel Lane, Suite 103
Fort Mohave, Arizona 86426
Ph: 928-460-SCAN(7226) Fax: 928-447-6113

Medical Record Release/Request Form

By completing this form, you are helping us by providing access to your prior medical records to compare with your new exam. If you do not remember all of the details of your prior exam, our staff will try to assist you in locating those records. Providing comparison images is extremely helpful to the radiologist during the interpretation of your new exam and sometimes eliminates the need for additional imaging.

PATIENT and REQUESTOR INFORMATION

Patient Name _____ **MRN Number** _____

DOB _____ **Patient Phone #** _____

Name of Person or Physician Requesting Records _____

☐ **Written request** ☐ **Verbal order taken by:** _____ **Date:** _____ **Time:** _____

TYPE OF MEDICAL RECORD REQUESTED - Check all that apply

☐ **Report** ☐ **Images on Film** ☐ **Images on CD** **List specific exams and dates of service requested below:**

PURPOSE OF MEDICAL RECORD REQUEST - Check all that apply

☐ **Dr. Appt.** ☐ **Comparison** ☐ **Biopsy** ☐ **Surgery** ☐ **Moved** ☐ **Patient to Keep** ☐ **Other:** _____

DELIVERY METHOD

☐ **Records to be Picked Up at Center**.....**By:** _____

☐ **Records to be Mailed / E-mailed**.....**To:** _____

Address/E-mail Address..... _____

☐ **Records to be sent via Certified Mail**.....**To:** _____

Address..... _____

☐ **Records to be Faxed (Name/Number)**.....**To:** _____

☐ **Records to be Disclosed to Interpreter**...**To:** _____

FOR MAMMOGRAPHY ONLY:
I request that these ORIGINAL FILMS and REPORTS be released for: ☐ **Permanent Transfer** ☐ **30 days**

PATIENT AUTHORIZATION (***READ THIS SECTION TO PATIENTS MAKING VERBAL REQUESTS VIA PHONE)

I understand this authorization shall become effective immediately and shall remain in effect until three months from the date of signature, or until I revoke it in writing, whichever occurs first. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

Additionally, I understand that authorizing another person to pick up my records can include disclosure of services rendered, insurance payments and/or denials, all demographic information, which can include date of birth, policy number, home address, telephone number, employer, and any other private information on my behalf.

I authorize the above named Imaging Center/Medical Center to release medical records and information pertaining to diagnostic reports and/or images for the above named patient.

Signature of person requesting records _____ **Date** _____

If submitted by mail, email or fax, Patient Signature was compared to signature on file ☐ **Yes** ☐ **No**

Authorization in paragraph above taken by verbal order as documented at top of form ☐ **Yes** ☐ **No**

*** If Authorized Representative, relationship to patient:** _____

MEDICAL RECORD RELEASE FEES

I agree to pay any fee associated with copying, reviewing and mailing the above records/images as follows:
Delivered directly to another medical facility: No Fee Mail: Applicable postage fees Fax or eMail (report only): No Fee
Delivered to patient or non-provider third party: 1st copy free, 2nd copy current price per film/CD Total $ _____

ID VERIFICATION OF PERSON PICKING UP OR INTERPRETING MEDICAL RECORDS

Patient / Authorized Representative IDENTIFICATION was verified by viewing photo ID ☐ **Yes** ☐ **No**

Print Name: _____ Date _____

Signature: _____ Relationship to Patient _____

FOR INTERNAL USE ONLY

Medical records prepared and verified by (*employee signature*) _____

Medical records verified and released by (*employee signature*) _____