Request for Radiology Images

Phone 503-815-2386 Fax 503-815-2485

Patient Name ___________________________________ **Phone Number** (____) ______- ________________

Date of Birth ______/______/______ **Medical Record #** ________-_______-__________

Address ____

City **State** **Zip**

Purpose of Request: ❑ Personal ❑ Legal ❑ Continuing Healthcare ❑ Other ______________________________

Please release the following images from Tillamook Regional Medical Center:

Images with dates of service: ____

____

Format Requested:

❑ **Dicom Disc** – Discs will be available for pick-up in 24 – 48 hours ❑ Please include written report

Select One: ❑ Patient will pick up at information desk ❑ Mail to patient at address above

❑ Mail to other Name: ____

Address: ____

City, State, Zip: ____

❑ **Electronic Transfer (Push)** – Available for transfer to the following facilities only:

Circle One: Adventist Medical Center – Portland Tuality Healthcare Portland Providence St. Vincent

OHSU Rinehart Clinic Legacy Health

❑ **Please fax written report to office/facility**: ____

Attn: ____ Fax Number: ____

Restrictions: I understand the information released may be subject to re-disclosure by the recipient and may no longer be protected.

Rights: I understand I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment (see page 2 of this form for certain exceptions). I may inspect or copy any information to be used and/or disclosed under this authorization in accordance with organizational policy. I understand that I have the right to revoke this authorization in writing (see page 2 of this form). My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization. This authorization will expire on ___/___/___, or one year from date of signature if not otherwise specified.

Signature ____ Date & Time _________________________________

Patient/Legal Representative

If signed by other than patient, indicate relationship: ____

FOR OFFICE USE ONLY

Requested internally by ________________________ Ext. _________ Department ____________ Date _________

[Patient Label]

FOR OFFICE USE ONLY

Date Received ____

Date Information Released ____

❑ Copy of verification of identity if individual and/or legal representative obtained/filed

Notes ____

____

Medical Record Number ____________________________________ Clerk Initials _______________

REVOCATION OF AUTHORIZATION

In accordance with provisions of the Notice of Privacy Practices, I hereby revoke the:
❑ Above Authorization

❑ Authorization releasing information to ____

❑ Authorization dated ____

____
Signature (Patient / Legal Representative)   Date   Time

If signed by other than patient, indicate relationship

____

FOR OFFICE USE ONLY

Date Revocation Received ____

Medical Record Number ____________________________________ Clerk Initials ______________

EXCEPTIONS

The exceptions noted in the Rights section on page 1 of this form include:

a) Authorization for research
b) Authorization for health plan enrollment
c) Authorization solely for the purpose of creating protected health information for a third party