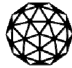

Reno Diagnostic Centers
590 Eureka Avenue, Reno, NV 89512
775 323 5083
fax:775 323 2193

REQUEST FOR MEDICAL RECORDS

I, ____________________________________, request that Reno Diagnostic Centers 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_______________

Home Phone: ________________________ Work Phone: _________________________ (optional)

Method of delivery:

- ☐ Mail to address provided below
- ☐ Fax to number provided below
- ☐ I will pick up (Photo ID required)
- ☐ A representative will pick (Photo ID Required)

Name of authorized Representative_______________________________

☐ Deliver to Physician
*Physician Name___________________
*Physician name required for **ALL film** requests regardless of Delivery method

DELIVERY INFORMATION: ☐ Send to me at this address/fax ☐ Send to Physician at this address/fax

Mailing Address: ____
(Street) (Apt/Box#) (City, State, Zip)

Fax: (_____) _________________________

Records Requested:

Exam Date	Exam Type		
____________	_________________________	☐Report	☐Film
____________	_________________________	☐Report	☐Film
____________	_________________________	☐Report	☐Film
____________	_________________________	☐Report	☐Film
____________	_________________________	☐Report	☐Film

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 false pretenses is a criminal offense and punishable by law.

X____ ____________ ____________________
Signature of Patient or Legal Guardian Date Relationship to patient

FOR INTERNAL USE

Date of Receipt: ____________ Delivery Method: Mail Fax Other: ______________________

Date Processed: ____________ Processing Fees: $____________

Processed By: ____________ NOTES:____

Approved By: ____________ ____