RECORDS REQUEST

NEWPORT DIAGNOSTIC CENTER

Patient Name: ______________________ DOB: __________ MRN __________

Phone Number __________ Today's Date __________ Request Rec'd By __________

Exams Requested

Exam(s)	***Date(s)***

Records Requested

- ☐ Films
- ☑ CD (Dicom)
- (1) CD Quantity
- ☐ Report(s)
- ☐ Urgent (within the hour)
- ☐ ASAP (by end of day)
- ☐ Routine (24 hours)
- ☐ **Report(s) Printed**
- ☐ **CD(s) Created**
- ☐ **Films Printed**
- ☐ **Logged in MI**
- ☐ **Partially Logged in MI - Need to Resolve**

Delivery Method

- ☐ Mail __________
- ☐ Delivery __________
- ☐ Fax __________
- ☐ Fed-Ex F/E # or CC #: __________
- ☑ Patient Pick Up I am taking images to: __________
- ☐ Spouse/Relative/Other ☐ Notified: must have release/power of attorney from patient
- ☐ Facility Pick Up Name of Facility: __________

Pick up Date: __________ Time __________

Records Requested By

- ☑ Patient ☐ Spouse ☐ Relative ☐ Other __________
- ☐ Physician Office __________ ☐ Medical Facility __________

COMMENTS

RELEASE

By signing below, I acknowledge receipt of films and/or CD and accept responsibility for their safekeeping. I assume full responsibility for records released pursuant to this authorization and agree to hold harmless Newport Diagnostic Center for any action related to release of these records. Records may not be re-released without written authorization by the patient, unless permitted by law.

Film Originals: I am aware that Newport diagnostic Center is unable to reproduce damaged or misplaced original film(s). I agree to return original films within 30 days of receipt.

Film Copies / CD's: You may retain these for your records. The first copy is provided to you as a courtesy. There will be a charge for any additional copies ($15 for CD's and/or, $15 per sheet of film).

______________________________ Patient/Guardian Signature

__________ Date

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