MEDICAL IMAGING OF MANHATTAN, LLC

Medical Records Release / Request Form Page 1

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 INFORMATION

Patient Name:		Date of Birth:	
Address:		Home Phone #:	
Email:		Cell Phone #	

TYPE OF MEDICAL RECORD REQUESTED - Check all that apply

❑ Mammogram	❑ Sonogram	❑ MRI	❑ Bone Densitometry	❑ Other

Our standard is to supply your digital images on radiographic film. Please notify us if your doctor requests these images on disk, **instead** of film, to avoid additional fee - Check off applicable: ❑ Films ❑ CD (DICOM Format)

PURPOSE OF MEDICAL RECORD REQUEST - Check all that apply

Are you leaving Medical Imaging of Manhattan? ❑ **YES** ❑ **NO**

If "Yes" please check the reasons that apply:
❑ Medical Insurance ❑ Financial Difficulties ❑ Moving ❑ Other

If "No" please check the reasons that apply:
❑ Appointment with a breast surgeon or oncologist. When? ____
❑ For my own records ❑ Other ____

Your record request may take 3-5 business days to complete, unless otherwise arranged. The process of printing your records will not begin until written authorization is received and any applicable payment is received.

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

I understand that 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 comes 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 name 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 document at top of form: ☐ **Yes** ☐ **No**

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

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) ____

Patient Name: **MRN:**

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OPTIONS FOR OBTAINING MEDICAL RECORDS - Please choose one

❑ Pick up at the office (We will notify you when your records are ready.)

❑ Deliver records to the below address

Name/Facility:		Phone #:	
Address:		Apt #:	
City:		Zip Code:	

** Note: There is ***NO CHARGE*** for the ***FIRST*** request of images from a specific date of service. If you wish to obtain a ***SECOND*** copy of the ***SAME*** images now or in the future, there is a $13 charge per date of service and this includes the reports, if duplicates are on films. There is a $6.50 flat fee if the requested duplicates are on CD (Dicom Format) and this includes reports.**

For Exams Released on CD	
One exam on 1 CD with a printed report	$6.50, includes the report
Multiple exams on 1 CD with printed reports	$6.50, includes the reports
Multiple exams on multiple CDs with printed reports	$6.50 per CD, includes the reports
For Exams Released on Film	
One exam report and up to 4 films	$13.00, includes the reports
Additional films	$3.50 per sheet of film, includes the reports

DELIVERY OPTIONS

		CHECK ONE
Manhattan Only (Messenger Service)	**$16.95 Fee for standard delivery (next day)**	❑
	$24.90 Rush fee (same day delivery)	❑
Out of Area Delivery (UPS)	**$9.06 Fee for standard delivery (2-3 days)**	❑
	$13.44 Rush fee (next day delivery)	❑

******* Payment must accompany this form if records are being delivered or for duplicate requests********

METHOD OF PAYMENT

Personal Check ❑ **(Make checks payable to RadNet)**

Credit Card ❑ **VISA** ❑ **MASTERCARD** ❑ **AMEX**❑ **DISCOVER** ❑

______________________________ ____/____ ______________________________

Last Four Digits of Credit Card Number Only — Exp Date — Signature

***** INCOMPLETE FORMS WILL NOT BE PROCESSED*****

FOR INTERNAL USE ONLY

Date Sent/Ready _______________

❑ MESSENGER - Choose one ❑ STANDARD ❑ RUSH

❑ UPS - Choose one ❑ STANDARD ❑ RUSH

❑ PATIENT PICK UP IN OFFICE

Patient Name: **MRN:**