IOWA RADIOLOGY
REQUEST TO SEND PROTECTED HEALTH INFORMATION TO SELF

As a patient of Iowa Radiology, you are entitled under federal law to request your personal protected health information for yourself. Please complete this form and submit it to **medrecords@iowarad.com** or via fax at (515) 226-9812. Once received, the information will be used to verify your identity, and your request will be processed.

Patient Name: _____ **Birth date:** _____

Patient Phone Number: _____

Date of service: _____**Type of service:** ___ **PET/CT** ___**X-ray** ___**Dexa** ____**CT** ____**US** __ **MRI of**_____

Information requested: Report: _____ **Images via USPS (IMAGES MAY NOT BE EMAILED):**_____

I would like Iowa Radiology to SEND VIA USPS, a disk with requested images to:

_____

PRINT Address, city state zip to mail disk

I will PICK UP at Iowa Radiology Clive / Downtown / Ankeny: circle one

I understand the revocation will not apply to information that has already been released in response to this authorization.

I understand that Iowa Radiology is given thirty days to process my request for access.

This authorization will expire one year from the date of signature.

By signing below, I acknowledge and agree to the above conditions.

_____ _____

Signature of Patient **Date**

_____ _____

Medical Records Signature Date request fulfilled.

Receipt of Reports/Images:

_____

Signature of Patient/Authorized Party Date: