US Radiology Specialists
Imaging and Interventional Partners

Request to Inspect or Obtain Copy of Patient Records

This form is to be used when a patient requests to inspect or obtain a copy of his/her own medical or billing record. This form should not be used to send records to a third-party (use the Authorization for Use and Disclosure of Protected Health Information Form).

Patient's Legal Name: _____

Address: _____ DOB: _____

City: _____ State: _____ Zip Code: _____

Inspect:

____ I would like to inspect a copy of my medical or billing records. Please contact me to arrange a time.

Obtain:

____ I would like to obtain a copy of my below records:

_____ Examination Notes
_____ Progress Notes
_____X-ray or Imaging Reports
_____ Discharge Instructions
_____ Entire Chart
_____Other: (describe) _____

_____Consultations
_____ Laboratory Reports
_____ X-ray or Imaging Films/Images
_____ Billing Records

Format: ____ paper copy or ____ electronic copy

Delivery:

____ I will pick up the records. Please call me when they are ready.

____ Please send the records to me:

____ Mail to my home address on file

____ email to my email address on file. *I understand that transmission by email may be unsecured and accessible by third-parties during transmission. I have been warned of the risk and request USRS to proceed.

_____ _____
Signature of Patient/Personal Representative* Date

*If a Personal Representative, provide relationship and authority (e.g., parent, legal guardian, Power of Attorney). _____

INTERNAL USE ONLY

Date payment received (if applicable) _____ Amount received _____Check Cash CC

Date records sent _____ Sent By_____