

# UNIVERSITY ORTHOPAEDIC CLINIC AND SPINE CENTER

## Policy 9-X X-Ray and MRI Images

### FORM REQUEST TO INSPECT AND COPY PROTECTED HEALTH INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Patient Address \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_  
Street

\_\_\_\_\_ City, State, Zip Chart # \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Cell # \_\_\_\_\_

Did a UOC Physician Refer you to another physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

If Yes, what Physician \_\_\_\_\_

If No, Purpose of Request \_\_\_\_\_

I would like to request a copy of my X Ray and/or MRI Images, and I know that if indicated below, this process may incur a fee and if so, I am responsible for paying this in advance. The charge for each CD is \$20.00 per CD.

There will be a charge today \_\_\_\_\_ UOC Staff Initials \_\_\_\_\_

There will not be a charge today \_\_\_\_\_ UOC Staff Initials \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
Chart #