OREGON IMAGING CENTERS

Request to Send Records to Other Providers

Patient Last Name **Patient First Name** **DOB**

Images Requested **Body Part**

Who needs the records?

☐ **Provider/Facility (please populate name)**
Name of contact person in office?
Name: **Phone Number:**

☐ **Patient** (pick up ONLY. Must use Request for Health Records form for all other release methods.)

Record Type:

☐ **Images on CD**
☐ **Images via PowerShare. MUST provide network name:**
☐ **Reports**

Delivery Method:

☐ **Fax** (must populate number) **Fax Number:**
☐ **Office to pick up** ☐ **Patient to pick up** ☐ **UD** ☐ **RBP**
☐ **Mail** (must populate address below)
Street Address or PO Box
City **State** **Zip**

Does the patient have a follow up appointment? ☐ **Yes. Provide appt date:** ☐ **No**

****Other Comments:**