NORTH COAST Radiology Group

Form For

Request for radiology records

I,_____Date of birth _____

(Patient name)

of _____

(Patient address)

☐ will collect in person or

☐ give consent to_____to collect

(Name of Person Given Consent)

☐ a list of personal information stored in my medical record such as address, list of all appointments etc

☐ the report(s) for appointments listed below (date & description):

☐ the images for appointments listed below (date & description) to be provided by:

☐ printed film ☐ CD ☐ USB

1. _____
2. _____
3. _____
4. _____
5. _____

I acknowledge and agree that where copies of previous reports and images are requested, a fee may be applicable. Please ask our reception staff for a quote. There is no cost for the first print of images.

Patient signature _____

Date signed _____

Note: If the patient is under 16 or due to physical/mental inability to sign on their own behalf a parent/guardian/advocate is to sign.

Name if not patient: _____

Office Use

Request date:_____ ☐ Patient / agent waiting or date required _____

Receptionist_____ Tech _____

Date and time provided _____

Photo ID Confirmed: ☐ Licence ☐ Passport ☐ Proof of age card

Report distribution approved by _____ Sign _____