Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You"℠

Request for Release of Original NIC Medical Records

As a patient, you are entitled under federal law to access your personal protected health information maintained in a "designated record set." In order to process your request for access, please complete this form in its entirety.

I hereby request **Steinberg Diagnostic Medical Imaging (SDMI)**, to release my original medical records. I understand that I am taking possession of the original medical record in its entirety and no copies will be retained. I acknowledge that SDMI strongly recommends that I provide medical record to my current physician for appropriate continuation of care. I hereby release SDMI from any and all liability arising from release of my medical records to me and for all uses and disclosures of my medical record and any related information.

Name		Date of Birth	
Street Address	City	State	Zip Code
Telephone Number		Cell Number	
Date of Request			

Delivery Method

❒ I will return to SDMI and pick up the copy when it is ready.
❒ I would like SDMI to send a copy via US mail to my above address or:

_____

SDMI will charge a fee for mailing USPS First Class $ **30** or Fed Ex Ground **$50**.
I also understand that I may am required to pay the fee in full before I can obtain the record.

I understand that ***SDMI*** is given thirty days to process my request for access if my information is maintained on-site, sixty days if the information is maintained off-site, and that ***SDMI*** may extend the deadline by an additional thirty days if I am notified in writing of the extension. By signing below, I acknowledge and agree to the above conditions.

_____ _____
Signature of Patient, Patient's Representative or Legal Guardian Date

_____
Print Name if Personal Representative or Legal Guardian
(If Personal Representative, please provide proof of identity and/or describe authority):