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

Release of Original NIC Medical Records
Third Party

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 NIC record. I understand that I am authorizing the release of original mammogram film and that I am responsible that they are returned to SDMI within **60 days of receiving.** In the event they are not returned, I understand that the mammogram will no longer be a part of my NIC patient record and any future requests for the mammogram cannot be processed. By signing below I agree and understand all the above. 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			

Reason for Release

❒ Insurance ❒Transfer of Care ❒ Legal ❒ Other_____

Authorize Release of:

❒ Entire NIC Record

❒ Date of Service_____

Authorize Release to:

_____

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. 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):