PATIENT REQUEST FOR PERSONAL MEDICAL RECORDS

Date Requested: _______________

Patient:____ **DOB:** ___________

Patient Address: ____

Patient Telephone: ______________________________

Type of Exam:________________________ **Date of Service:** _______________

1. I, ______________________________ (patient name) request a copy of my:

   ☐ Imaging report ☐ CD

   for any imaging for which I have received. I assume full responsibility for the report and/or CD in my possession and I understand that I do not need to return.
2. I understand that this request will be reviewed by the Privacy Officer, who shall respond within 10 days from the date on which MDR receives the request.
3. I accept the conditions stated above.

The signature of the patient must be obtained unless the patient is an unemancipated minor under the age of 18 (where parent or guardian must sign) or otherwise lacks capacity to sign (where health care agent, next of kin or legal guardian must sign).

____________________________________	________________________	____________
Patient/Parent/Legal Guardian/Health Care Agent Signature	Print Name	Date/Time
____________________________________	________________________	____________
Interpreter Signature (if required)	Print Name	Date/Time
____________________________________	________________________	____________
Witness Signature	Print Name	Date/Time
____________________________________	________________________	____________
Privacy Officer Signature	Print Name	Reviewed Date