Optum

Southwest Medical®
Part of Optum®

P.O. Box 15645
Las Vegas, NV 89114-5645
**Fax:** 1-702-877-8370

# Authorization to disclose protected health information (PHI) – radiology records/files

This request to release imaging films/records will be returned if not completed in its entirety.

**To our patients:** Your radiographic films are a very important part of your health records and are the property of Southwest Medical Associates.

**For mammography CD/films,** please call 1-702-877-5125 option 5, Monday–Friday, 8 a.m.–4:30 p.m.
Mammograms done prior to 2012, please allow 3-5 business days for processing.
Mammography film to be picked up at 888 S. Rancho Dr., 4475 S. Eastern, 2845 Siena Heights and 2704 N. Tenaya.

Patient name: _____ Medical record number: _____

Address: _____ City: _____ State: _____ ZIP: _____

Date of birth: _____ Phone: _____

Include dates where appropriate – **From** (date): _____ **Through** (date): _____

☐ Routine X-ray ☐ CAT scan ☐ Ultrasound ☐ Fluoroscopic study
☐ Mammogram ☐ Bone density (DEXA scan) ☐ X-ray reports

Radiology and imaging records may include related biopsy and other pathology reports.

Southwest Medical Associates to release to: ☐ Requestor ☐ The following individual or organization

_____
Name Phone number Fax number

_____
Address City, State, ZIP code

Date needed by: _____

**Reason for request:** (please check one) ☐ Medical care ☐ Insurance ☐ Personal ☐ Attorney

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Radiology Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If left blank, this authorization will expire 6 months from the date it is signed.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 C.F.R. § 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules. If I have questions about disclosure of my health information, I can contact the Health Information Management Department and obtain a copy of the Notice of Privacy Practices.

Signature of patient — Date of signature (required)

Signature of parent, guardian or personal representative (if necessary) — Date of signature (required)
(If guardian or personal representative, attach supporting documentation)

**A 20 minute wait is to be expected for each request.**

I wish to receive this information on:

☐ CD of digital images (available at any site)
☐ Hard copy images (available at any site). Film will only be printed upon the written request of a provider or for continuity of care.

| **Department use only** | | |
|---|---|---|
| Request taken by: | Date: | Notes: |
| Prepared by: | Date: | |
| Photo ID check and released by: | Date: | |
| Received by: | | |

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