



# INTERMOUNTAIN MEDICAL IMAGING

## FILM/REPORT REQUEST

### PRIVACY POLICIES AND PROCEDURES

Contact Person: \_\_\_\_\_  
Verification Process: \_\_DOB \_\_Photo ID \_\_Address  
Requestor's Phone Number: (\_\_\_\_)\_\_\_\_\_

Patient Name: \_\_\_\_\_ EMPI# \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Exam(s)/Report(s) to be filmed/printed – Date of Exam – Location

- 1) \_\_\_\_\_  
CD —or— Films — Report Done \_\_\_\_\_  
Initials
- 2) \_\_\_\_\_  
CD —or— Films — Report Done \_\_\_\_\_  
Initials
- 3) \_\_\_\_\_  
CD —or— Films — Report Done \_\_\_\_\_  
Initials
- 4) \_\_\_\_\_  
CD —or— Films — Report Done \_\_\_\_\_  
Initials
- 5) \_\_\_\_\_  
CD —or— Films — Report Done \_\_\_\_\_  
Initials

To be:  Delivered  Mailed  Faxed to: (\_\_\_\_)\_\_\_\_\_  Pt/pt rep pick up

TO: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Pt Rep P/U: \_\_\_\_\_

To be picked up/delivered from: \_\_\_\_ Meridian \_\_\_\_ Boise \_\_\_\_ EHP \_\_\_\_ PC \_\_\_\_ AI's MRI

Date needed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time Needed: \_\_\_\_\_am/pm **ROUTINE/RUSH**

Request taken by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_\_

Request completed by: \_\_\_\_\_

Authorized Person: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature)

Relationship to patient: \_\_\_\_\_

Describe authority to act on behalf of patient (e.g. parental rights, power of attorney): \_\_\_\_\_