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: ☐ e-Mailed ☐ 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 ____Al'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): _____

Mail completed form to: IMI - Meridian 2929 E Magic View Drive Meridian, ID 83642
Or fax to IMI - Attn: Films & Reports 208.954.8143