SimonMed® Imaging
See Tomorrow Today®

To receive your medical record(s), please complete the following steps in their entirety:

1. Fill out each section of the "Authorization to Release Protected Health Information" form.
2. You may choose to pick up your medical record(s) by hand-carrying the form to any SimonMed Imaging center, or you may submit the form via fax or email and have your medical record(s) sent to you.

    a. **Hand Carry/Pick Up**: Please take the completed "Authorization to Release Protected Health Information" form with a valid ID to any SimonMed Imaging center. In certain circumstances, you may experience a wait time to process your request on-site.

    b. **Fax**: Please fax the completed "Authorization to Release Protected Health Information" and a photo copy of your valid ID to 602-302-5958. All requests will be expedited as quickly as possible (no longer than 30 days).

    c. **Email**: Please email the completed "Authorization to Release Protected Health Information" and a photo copy of your valid ID to MedRecReq@SimonMed.com. All requests will be expedited as quickly as possible (no longer than 30 days).

Please note, a fee of $50 per set applies for any film requests. As a courtesy to our patients, any request for reports and/or a CD containing images will be provided at no charge. If the "Authorization to Release Protected Health Information" form is incomplete, you will be contacted by a Medical Records staff member to request additional information.

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Authorization To Release Protected Health Information

Please fill out each section below.

Patient Name: _____ MRN: _____

Date of Birth: _____ Alias/Maiden Name(s): _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

To Disclose My Records: (Please check the exam(s) you are requesting reports/images for.)

- ☐ All medical records
- ☐ CT
- ☐ Sonogram/Ultrasound
- ☐ MRI
- ☐ X-Ray
- ☐ Mammogram
- ☐ PET
- ☐ Dexa/Bone Densitometry
- ☐ Nuclear Medicine
- ☐ Other: _____

Please provide a description of the exam you are requesting reports on (date, exam, body part): _____

_____

Are you requesting (check all that apply): ☐ Reports ☐ CD ☐ Films

Please note, a $50 fee per set of films will apply. All films and CDs are promptly prepared at time of pickup.

Please indicate how you would like these to be received:

- ☐ Fax to: _____ Attn: _____
- ☐ Mail to: _____
- ☐ Email to: _____
- ☐ Collect in person: *I understand that my records will only be provided to myself or any individual(s) listed below. A photo ID is required at time of pick up.*

By my signature below, I authorize SimonMed Imaging to release my protected health information to the following individual(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal and/or state privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, payment, eligibility for benefits unless allowed by law. I understand this authorization may be revoked in writing at any tie, except to the extent that action has been taken in reliance on the authorization. Unless otherwise revoked, this authorization will expire 1 year from the date of signature. You have the right to revoke this authorization, except to the extent the custodian of records has relied on it, by sending your written request to the Privacy Officer at: 16220 N. Scottsdale Rd., #600, Scottsdale, AZ 85254.

_____ _____

Patient or Authorized Representative Signature | Date of Signature

_____ _____

Printed Name of Patient or Authorized Representative | Relationship to Patient