REQUEST TO INSPECT AND/OR COPY MEDICAL RECORD

You have the right of access to inspect and/or obtain a copy of your protected health information contained in your medical record at Memorial's Valley Imaging. Please fill out this form and return to Memorial's Valley Imaging at 314 South 11th Ave, Suite B, Yakima, WA. You will be contacted within 15 days regarding this request. If access has been denied, you will be informed in writing of the reason(s) why. There may be a charge for copies of the medical record.

______________________________	______________________________
Patient Name	Today's Date
______________________________	______________________________
Social Security Number	Date of Birth
______________________________	______________________________
Address	Telephone Number
______________________________	______________________________
Requested By	Signature of Patient/Representative

Requested Information: ____

____

Office Use Only – Information Released:

Report:	Date of Study:	CD:	Date of Study:
☐ CT	____________	☐ CT	____________
☐ MR	____________	☐ MR	____________
☐ Ultrasound	____________	☐ Ultrasound	____________
☐ X-Ray	____________	☐ X-Ray	____________
☐ PET/CT	____________	☐ PET/CT	____________

Film Library Request by: __________ (Date) __________ (Initial)

Prepared by: __________ (Date) __________ (Initial)

Hand Delivered to patient by: __________ (Date) __________ (Initial)

OR

Mailed to patient by: __________ (Date) __________ (Initial)

MEMORIAL'S VALLEY IMAGING
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YAKIMA, WA 98902
(509) 248-7380