P: 952.595.1100
F: 952.942.3361
www.vrad.com

11995 Singletree Lane, Suite 500
Eden Prairie, MN 55344

PATIENT REQUEST TO RECEIVE COPY OF RECORDS FROM VIRTUAL RADIOLOGIC PROFESSIONALS AND/OR VIRTUAL RADIOLOGIC SERVICES ("vRad")

PATIENT'S FULL NAME and ADDRESS
Provide current name and name at time of patient's radiology procedure, if different.

Name:_____

Address:_____

PATIENT or LEGAL REPRESENTATIVE'S E-MAIL ADDRESS: _____

PATIENT OR LEGAL GUARDIAN'S PHONE #: _____

PATIENT'S DATE OF BIRTH: _____

Date(s) of service associated with request: _____

Location(s) patient received radiologic imaging (name of facility, city, and state):

_____

Describe the information you are requesting:

☐ Radiology Report(s)
☐ Bill to patient and/or patient's insurance company(ies)
☐ Other _____

Note that vRad does not ordinarily have radiology images for more than 45 days from date of service. You must contact the facility that performed the imaging for those.

To validate requester's identification and authority to receive patient's information, provide the medical record number associated with the patient: _____

☐ *Please mail information to above address.*

☐ *Please e-mail information to above e-mail address. vRad shall send the information via an encrypted email. However, vRad does not make any guaranty regarding the security of e-mail communications.*

Patient's Name: _____

I certify that this request is made voluntarily and that the information above is accurate to the best of my knowledge.

Signature of Patient/Legal Representative: _____ **Date:** _____

If Legal Rep., Print Name: _____ **Relationship to Patient:** _____
If other than parent, please provide copy of valid power of attorney for health care, or a copy of a court order appointing requester as guardian of the patient, or documentation establishing requester as next of kin.

vRad use only:

Individual who received request: _____ **Date request received:** _____

Verification of Identity (how performed): _____

☐ **Request approved** ☐ **Request Denied** **Date approved/denied:** _____

Date Fulfilled (copies delivered): _____ **Individual who fulfilled:** _____

Reason for denial, if applicable: _____