BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

PATIENT OR HEALTH PROVIDER RADIOLOGY IMAGE REQUEST FORM

Requester's name: ____________________

Requestor's contact eg. phone/email: ____________________

Patient's first name: ____________________ Patient's surname: ____________________

NHI ____________________ DOB ____________________

Email address in which the download link will be sent: ____________________

Examination/s Required: Exam Date:

1. ____________________ ____________________
2. ____________________ ____________________
3. ____________________ ____________________

Reason for Request

If an email address cannot be provided a DVD can be collected from Radiology

REQUESTER Must Complete

I certify that the Patient or Legal Guardian is aware of and has authorised this request.
Upon signing this form, you consent that any data transferred electronically is done with the acknowledgement that any breach of privacy, by the DHB, as a result of the electronic transfer, would be unintentional.

Signature: ____________________ Date: ____________________

RADIOLOGY TO COMPLETE

Proof of identity obtained by: ____________________

Signature: ____________________ Date: ____________________

Images sent via DVD or Email by: ____________________

Signature: ____________________ Date: ____________________