HDI High Desert Imaging

976 Mountain City Highway Elko NV 89815 775.621.5800

NOTIFICATION EXAM AUTHORIZATION

Patient Name:_____

Date of Birth:_____ Cell Phone:_____

I grant HDI permission to share my information using the following methods:

☐ Answering Machine / Voice Mail

☐ Can we call you at work? _____ YES _____ NO
Initial Initial

If so, Work phone:_____

HDI may choose to contact you by email for exam notifications or information about our services.
Would you like to opt-in to receive emails from HDI? ☐ Yes ☐ No

Email Address:_____
(Information you provide will not be shared with third parties.)

☐ I give my consent to have results (via written report only) sent by secure email to the above address

I give permission for Provider and / or employees of High Desert Imaging to notify me about my healthcare, including, but not limited to, referrals for appointments made or to be scheduled, records request, images to be released and other related information.

I grant HDI permission to share this information with the following people:

☐ Spouse
Name: _____ Contact Info: _____

☐ Parent(s)

Name: _____ Contact Info: _____

☐ Other
Name: _____ Contact Info: _____

This authorization does not expire, if you want to make changes to the notification you need to fill out a new form. Any changes must be in writing.

_____ _____
Patient / Guardian Signature Date

Rev. 05/21/2020